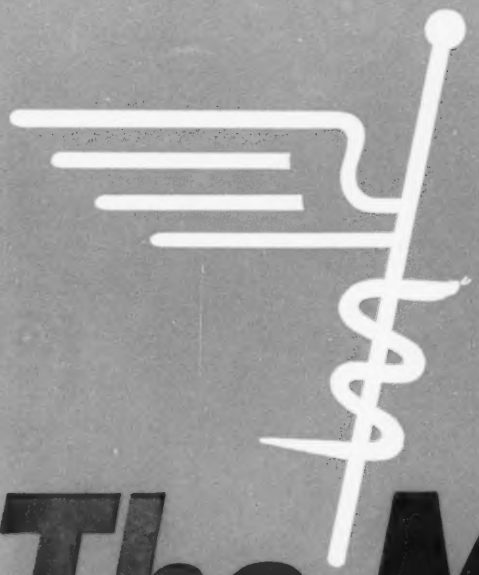

The Modern Hospital

JUNE 1952

New Rate Formula Makes Income Equal Outgo • Polio Foundation Presents New Forms for Hospital Payments • Time and Motion Studies in the Operating Room • Budget Plan • Spring Hospital Conventions • The Medical Society and the Hospital

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— first with the future in SPEED!

A Major Development in Commercial Cooking!

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This scientific fact concerning electricity makes possible a whole new concept of commercial cooking—"THE MODERN HOTPOINT METHOD." It is the basis of a brand new trend in advanced equipment design—Hotpoint's Custom-Matched Counter Line.

Here lightning speed is the secret of new standards of performance like this . . .

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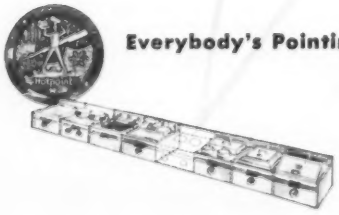

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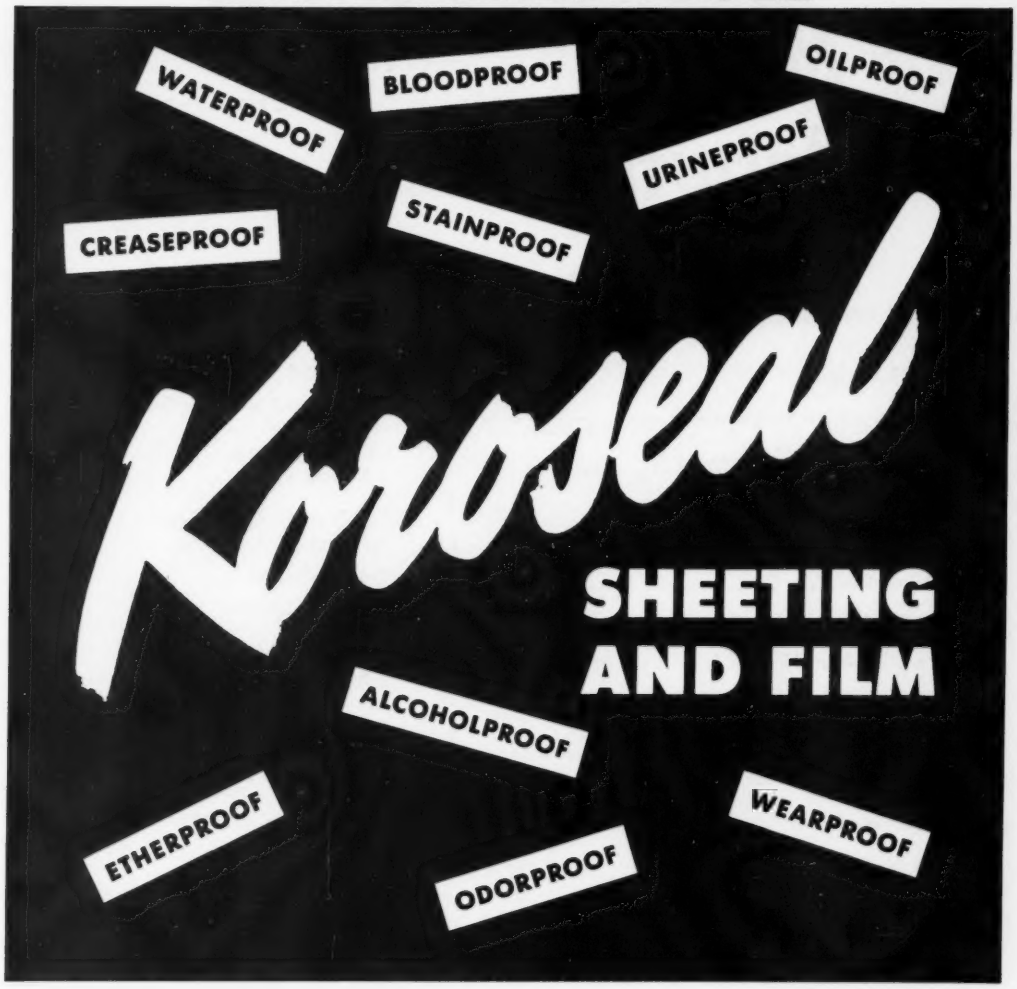

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The Modern Hospital

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JUNE 1952

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AMONG THE AUTHORS


Charles A. Turner

Charles A. Turner, whose article on hospital music appears on page 90, is assistant administrator of the Charles S. Wilson Memorial Hospital at Johnson City, N.Y. A graduate of the St. Lawrence School of Nursing at Ogdensburg, N.Y., Mr. Turner served in the navy hospital corps for three and a half years during the war. After his discharge from the service he took the hospital administration course at Northwestern University in Chicago. He served an administrative residency at Syracuse Memorial Hospital, Syracuse, N.Y., before going to his present position.


T. LeRoy Martin

T. Leroy Martin, who tells hospital people how to prepare a budget on page 82 of this magazine, tells hospital administration students at Northwestern University the same thing right along, and he has told the entire hospital field all about accounting in two books on the subject. Mr. Martin is professor of accounting and acting chairman of the department at Northwestern and a partner in Martin & Martin, Chicago accounting firm. Mr. Martin has a master's degree from Northwestern and a Ph.D. from Harvard University. During the war, he served as a lieutenant commander in the navy supply corps.


Dorothy Morgan

Dorothy Morgan, whose paper describing how housekeeping standards benefit the nursing department appears on page 130, is director of nursing service at the University of Chicago Clinics. After receiving her nurse's training in Canada and serving in a number of nursing positions there, Miss Morgan took the graduate course in hospital administration at the University of Chicago, getting her M.B.A. degree in 1949. In July of that year she went to St. Barnabas Hospital in Minneapolis as assistant superintendent. She became superintendent of St. Barnabas a year later, and shortly afterward she returned to the University of Chicago as director of nursing.


S. A. Ferguson

Stanley A. Ferguson is superintendent of Cleveland City Hospital—an institution that has given the hospital field such distinguished figures as James A. Hamilton, George Bugbee, and the late Dr. Charles T. Dolezal. A graduate of the University of Chicago course in hospital administration, Mr. Ferguson was a member of the administrative staff of the University Clinics for several years, serving as superintendent of Chicago Lying-In Hospital before he entered the medical administrative corps of the army early in World War II. After serving overseas with army hospitals, he returned to Lying-In, where he remained until he took the Cleveland City appointment three years ago. His paper on administrative problems in the dietary department appears on page 112.

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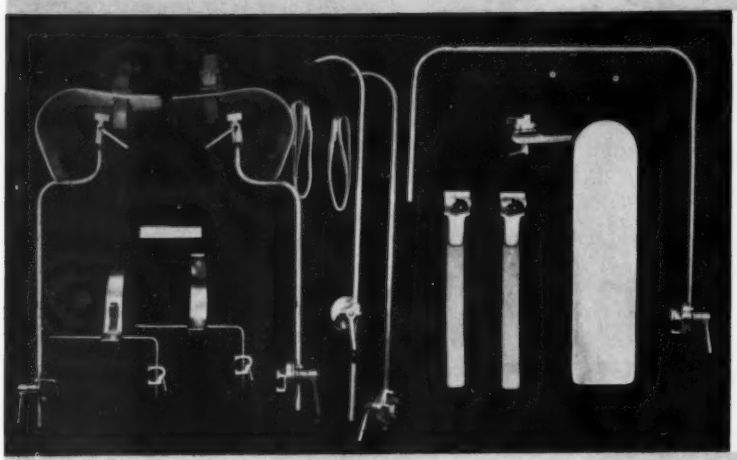

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Roving Reporter

Nursing Pageant Aids Recruitment

Like every other hospital throughout the nation, Ryburn Memorial Hospital, Ottawa, Ill., is in dire need of graduate nurses. The enrollment in the nursing school had dropped from 55 students to 32 students. The nurse recruitment program last year produced but eight new students.

At a meeting of the nursing school committee, which consisted of 10 women and four men, representing the hospital, the nursing school, local college, industry, labor and the various public health and welfare agencies, it was agreed that the situation was critical and that drastic action must be taken.

To bring this problem accurately and realistically to the people of our community, we decided upon a pageant called "Nursing Through the Ages." It had been given about 25 years ago by the Illinois State Nursing Association. We finally found costumes which had been stored in a warehouse and not used in all this time.

We met with the editor of the local newspaper and the director of the local radio station. After we convinced them of the necessity of interesting the entire population in our problem, they decided to give us their full cooperation. The newspaper published something about the pageant every other day for a period of approximately two weeks prior to its presentation. The radio station gave daily spot announcements. However, the emphasis was not so much upon the pageant itself, but rather on the reason for its being given. The theme throughout all our publicity was "The community must support its own nursing school and endeavor to bring students into our schools or they will be faced with the problem of selecting the lesser of two evils: Either we compete with the large cities on a financial basis to bring graduate nurses to our community, which would inevitably make the cost of hospitalization almost prohibitive, or we would have to continue to hire large numbers of untrained lay personnel which would naturally result in a lowering of the standards of our nursing care."

We invited the local high schools to prepare posters based on the theme of the pageant. All those who submitted a poster were invited to a tea and then the part they were playing in this community project was explained to them. These posters were placed throughout the various retail stores and office buildings in the city.

We placed the direction of the pageant in the hands of a well qualified woman and then invited people from all walks of life in our community to take part. Although the core of the performers was our own nursing school, and alumni association, we invited two lawyers, an automobile dealer, a factory worker, a union representative, a min-

"Nursing Through the Ages."

ister, a public health nurse, and many others to participate.

We drew a large group from the two high schools in town and found use for not only the high school's girl band but also additional high school girls who acted as usherettes. The public high school gave us the use of its auditorium, which is the largest assembly place in the community.

The services of musicians, stage hands, architects, carpenters and electricians were all donated free to the hospital. Props from the various department stores and movie houses in town were given free of charge. At this point, we figured that those taking part in the play or working in some capacity in the play, plus their families, involved about 2000 people and comprised an excellent cross section of our community.

The pageant, after six weeks of rehearsal, was presented to more than 1400 people who crowded into the auditorium.

What did all this amount to? Did it help our nursing school? Did it help our public relations? Yes, it did, very definitely. It was the first time in many years that our entire community had become aware of one local problem and expressed a concerted desire to do something about it. This was reflected by the many people who wrote to me, to the board of directors, and to the nursing committee, asking if they could help. The teachers in the high schools, both Catholic and public, pledged their all-out support to direct students into the nursing profession. The community became more aware of what our nursing school had to offer.

Six different organizations have not only pledged scholarships but are going to find the students to fill the scholarships. So far our director of nursing has received 15 applications. But, also important, she has received many letters from students in the first and second years of high school and also from the parents, requesting guidance in the type of studies their daughters should pursue, with the idea of their becoming nurses.

Having awakened the interest of the community in our nursing school it was then our problem to keep it stimulated. The local radio station came to the rescue. We now have a 15 minute broadcast, which I conduct every Tuesday, called "Your Community Hospital."

Considering objectively the approach to our problem, the pageant itself, and its results at this point, I feel that it was well worth the time and effort expended. We have been well rewarded by a wealth of good community relations, as well as an excellent start toward our September enrollment in the nursing school.

Well, that's our story, except to mention a few miscellaneous items:

1. We did not charge any admission for the pageant.

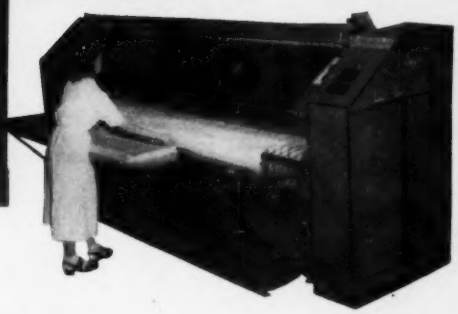
2. We invited surrounding hospitals to attend and participate.

3. The costumes for the pageant are now stored at our hospital as requested by the Illinois State Nursing Association, to be forwarded to any hospital desiring to produce "Nursing Through the Ages." We made four copies of the script as we revised and presented it.

4. At the present time we are duplicating the script and it will be available, free of charge upon request.

5. It also is not necessary that the costumes we have on hand be used by everyone desiring to do the pageant. It seems to me that having groups improvise their own nursing costumes would be an excellent means of interesting the community.—EDWARD W. GILGAN, *director, Ryburn Memorial Hospital, Ottawa, Ill.*

"DESSA TVA FOLDERS HAR FORMINSKAT BEHOF FOR SEX FLICKOR"



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Troy LAUNDRY MACHINERY

Reader Opinion

Tale of Cat Twisted

Sirs:

My attention has been called to an item "Cat Tale" on page 50 in the April issue of The MODERN HOSPITAL which, though intended to be amusing, seems not to be in the spirit of your usual editorial policy.

The "Cat" story is inaccurate and as far as the reference to the New York Orthopaedic Hospital is concerned, it is entirely untrue.

The New York Orthopaedic Dispensary and Hospital, established in 1868, was consolidated with the Presbyterian Hospital in 1945 and moved to the Columbia-Presbyterian Medical Center in December 1950. This move was not a financial consideration but was made in the interest of providing modern facilities for the care and treatment of orthopedic conditions and fractures in children and adults and to utilize the modern equipment and laboratories provided by the Columbia-Presbyterian Medical Center. Its teaching responsibilities in the College of Physicians and Surgeons were also a factor.

John S. Parke
Executive Vice President
Presbyterian Hospital
Columbia-Presbyterian Medical Center
New York City

Nursing Education Costs

Sirs:

I have read with much interest the cost analysis report from Wesley Memorial Hospital, "Nurse Education Costs Are Getting Too Big for Their Budgets," by Paul H. Keiser, in the April issue of The MODERN HOSPITAL.

I would not presume to prepare a critique of the article or the specific study at Wesley. To do so one would need to be thoroughly familiar with the operating situation there. Surely the school and hospital must feel a great satisfaction in having accomplished this joint project, since it is not a simple job and, moreover, because of its potential benefits to all concerned.

The analyst has set forth his procedure for all to see, a highly praiseworthy feat. Would that every report carried a clear description of the method of study. Whether one agreed with the choice of method is a matter of opinion. Anyone who has knowledge of the school of nursing, the hospital and the elements of cost analysis should be able to determine from this analysis whether the study is weighted in favor of the school, or the hospital, or strikes a middle ground. Could we ask for more!

Essential to the successful accomplishment of a cost analysis is that it be undertaken cooperatively by the directors of the educational programs and the hospitals concerned. Both have basic needs and uses for the resulting data; both have specific contributions to make. When it becomes a joint project common understandings are reached for the conduct of the study as well as in the application of its findings.

Cost analysis has been defined as an "interpretation of the findings resulting from the application of cost accounting over a particular period of time for a specific purpose." The purpose, then, affects the method used.

Once the data have been collected and analyzed, care should be exercised in their use. Inasmuch as costs and practices vary from school to school, interpretation and application of results should be confined to the individual institution for which the study was made.

It might be interesting to restate some of the results of a study which included some 40 schools.

One point which was noted is that head nurses tend to overestimate amount of time given to the educational program. This, of course, adds to the total and unit cost of the school. Incidentally, in another recent activity analysis of head nurses, still unpublished, upon verification it was found that the head nurses had significantly overestimated the amount of time spent on instruction of students.

Most data in the 40 school study show that of the total cost about two-thirds was for maintenance (housing, feeding, laundry, hospitalization and health), and the remaining one-third was for education.

Total income per student revealed a wide spread among the various institutions. No significant correlation ap-

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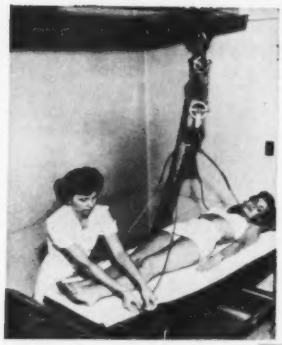

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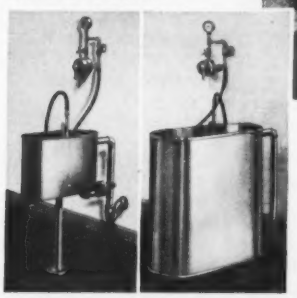

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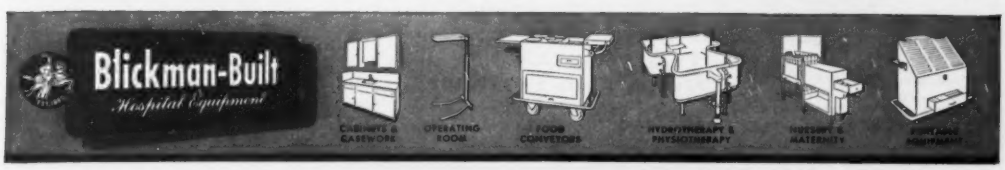

peared between per student income and the size of the hospital, size of the school, or ownership and control. Income appears to be more closely related to the number of hours of service given by students, the proportion of time spent away from the hospital on affiliation, the replacement value of student hours of service, the tuition and fees charged, and average hourly salaries of replacement groups. These and other studies have considered service given by students as replacement for both professional and nonprofessional personnel.

Similarly with costs, no significant correlation was demonstrated between cost per student and size of the hospital, size of school, and ownership and control. The range of costs is so great that any attempt to make comparisons among different institutions is not warranted.

Although there appears to be no significant statistical relationship between income and cost per student on the one hand, and size of school, size of hospital, ownership and control on the other, size of school does affect the relationship of total cost to total income in the individual school. There is evidence that excess of income above costs is higher in schools having larger average daily enrollment of students. Such factors as length of time at the home hospital, amount of time spent in other institutions on affiliation, length of student program of training, nursing and teaching staff, and kind of medical care given to patients greatly affect both the cost and income of a nursing school.

Louise O. Waagen
Chief, Nurse Consultant
Division of Medical and
Hospital Resources
Public Health Service
Federal Security Agency

Sit Down?

Sirs:

This letter is in reference to the article "Finance Commission Moves Ahead," written by your editor, Robert M. Cunningham Jr., and printed in The MODERN HOSPITAL, issue of March 1952. . . .

The Association of American Physicians and Surgeons is falsely referred to as "an organization which once proposed a sit-down strike of doctors in event a national health insurance program should be adopted."

The word "strike" is defined by Webster as an "act of quitting work." No member of A.A.P.S., and for that matter, no other ethical physician ever contemplated a withdrawal of his services from his patients. A.A.P.S. proposes merely that physicians exercise their constitutional right not to participate in schemes which are contrary to the public interest. Every socialized medicine bill introduced into Congress has recognized this constitutional right by stating: "Physicians are free to participate full time, part time or *not at all.*"

Denton Kerr, M.D.
President
Association of American Physicians
& Surgeons
Chicago

An action of the Association of American Physicians and Surgeons several years ago was referred to in the press at the time as a proposed "sit-down strike" in event a compulsory health insurance bill should become effective. Possibly this was unfair. We're not sure we understand how any large organization of physicians could remain outside a program including some two-thirds of the population without jeopardizing service to patients, but we are glad to publish Dr. Kerr's letter in full explanation of the position of the association.—ED.

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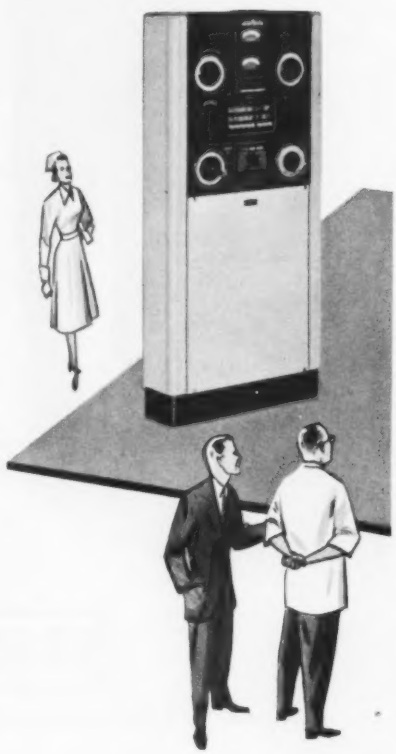
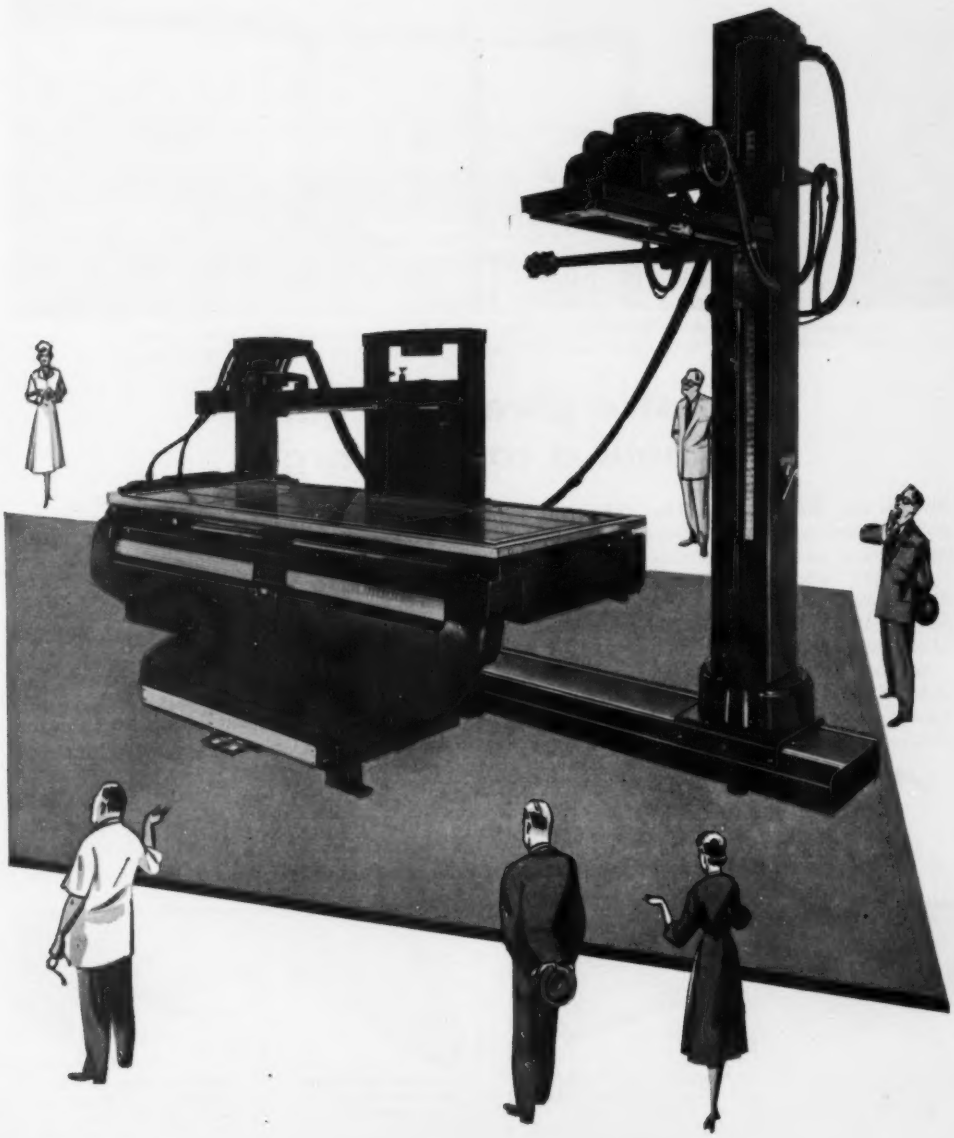


. . . Maxiscope has complete x-ray diagnosis



Combination Acoustical-Structural Ceiling of Fenestra "AD" Panels in Architectural Office—Walter R. Steyer Office Bldg., Los Angeles, California. The side wall at left is Fenestra "C" Panels. Architect-Contractor: Walter R. Steyer.

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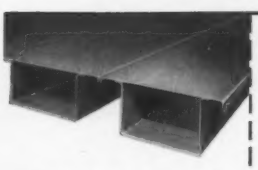
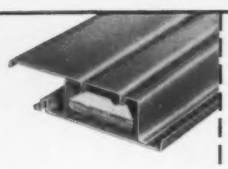
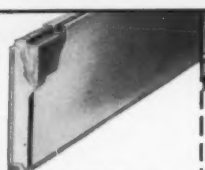
. . . engineered to cut the waste out of building



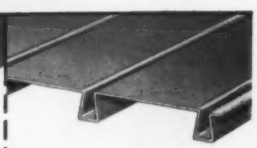
"D" Panels for floors, roofs, ceilings. Standard width 16". Depth 1½" to 7½".



Acoustical "AD" Panels for ceiling-silencer-roof. Width 16". Depth up to 7½".



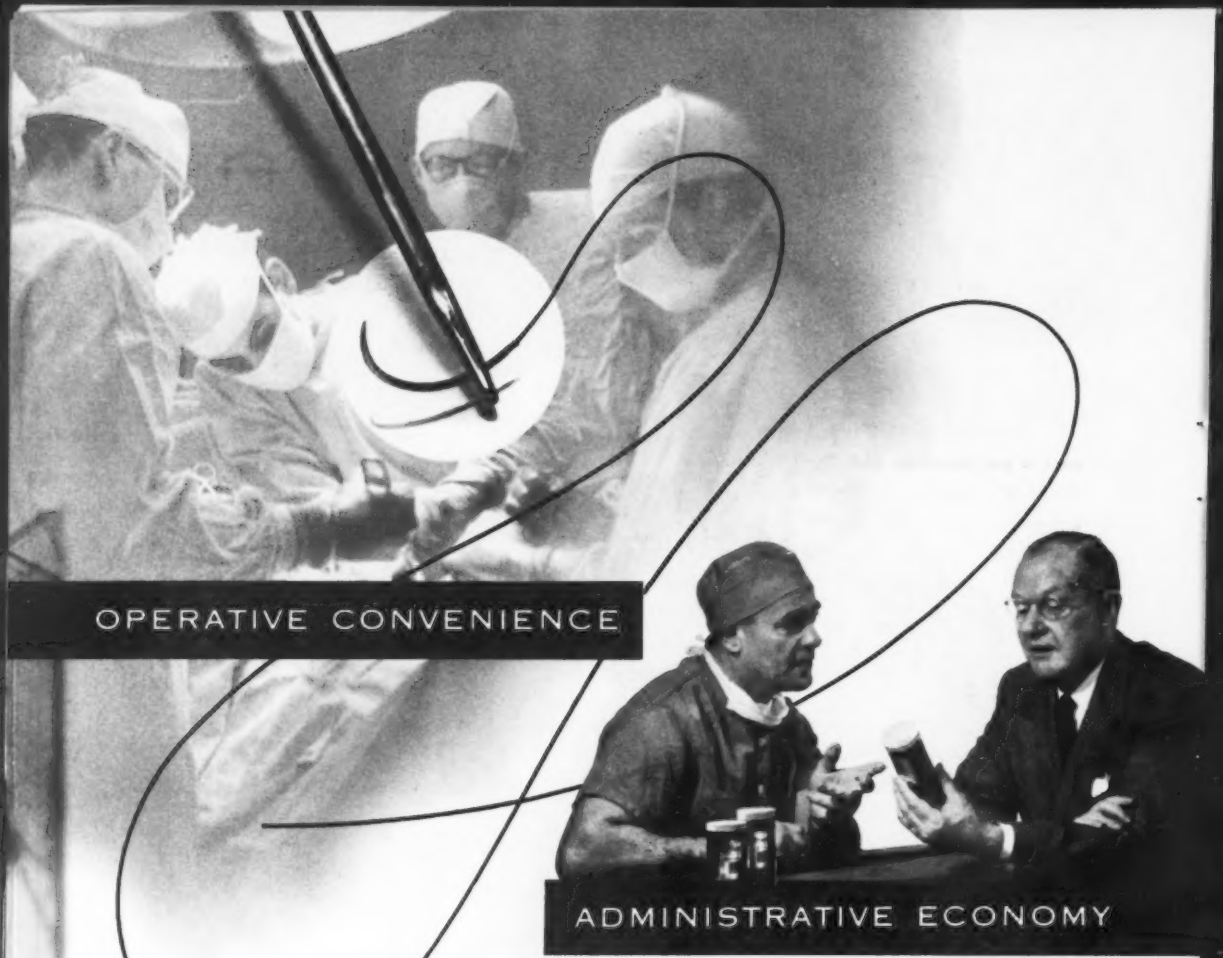
"C" Insulated Wall Panels. Standard width 16". The depth is 3".



Holorib Roof Deck. 18" wide—lengths up to 24'. Surface can be plain or acoustical.

INDEX TO ADVERTISEMENTS

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—29th Edition



ATRALOC® *Needle Sutures*

For the Surgeon...

ATRALOC provides outstanding conveniences:

- minimal tissue trauma — needle carries single strand
- improved points and constant sharpness
- longer, more useful flat area — needle won't turn in holder
- saves time of needle threading
- eliminates unthreading during operation

For the Hospital...

ATRALOC effects appreciable economies:

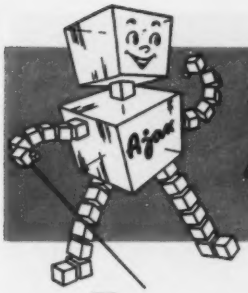
- minimizes needle inventories — fewer sizes and varieties needed
- saves nurse hours
- simplifies replacement problems
- eliminates needle preparation (cleaning, washing, sharpening)

SPECIAL ADVANTAGES OF ATRALOC SEAMLESS NEEDLES

ATRALOC Seamless Needles are needles of choice for general closure, obstetrics, gynecology and most procedures where catgut is indicated. They have a single temper throughout — optimal flexibility and uniform strength without soft spots or brittleness.

ETHICON
SUTURE LABORATORIES
INCORPORATED

SUTURE LABORATORIES AT NEW BRUNSWICK, N. J.; CHICAGO, ILL.; SAO PAULO, BRAZIL; SYDNEY, AUSTRALIA; EDINBURGH, SCOTLAND.



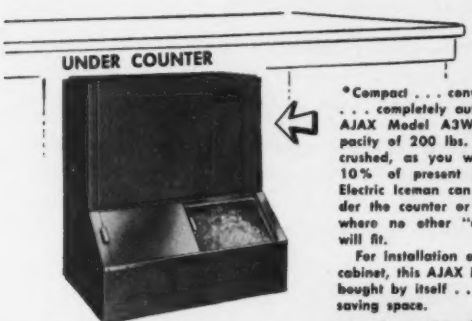
Ajax announces revolutionary NEW Electric Iceman!

. . . available in separate units according to need

1 ICEMAKER
2 CRUSHER
3 STORAGE
4 MOUNTING

THIS latest AJAX Electric Iceman is the answer to your problems, also. There is nothing else like it. It's compact . . . the answer to all tight space limitations. It can be bought in sections according to your requirements. It delivers ice in cubes or crushed, automatically . . . whenever and wherever you need it . . . in quantity up to 200 lbs. daily . . . and in larger amounts by multiple hook-up. Backed by AJAX reputation and SERVEL craftsmanship.

You, too, can save money, avoid waste, prevent shortage, in your ice requirements. Get the proof! Use the convenient coupon below. NOW . . . while you are thinking about it!

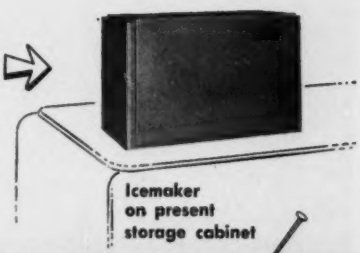


Icemaker and Storage

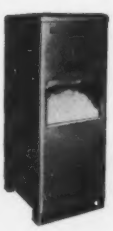
*Compact . . . convenient . . . adaptable . . . completely automatic . . . this new AJAX Model A3W-1 has a daily capacity of 200 lbs. of ice . . . cubes or crushed, as you wish . . . for around 10% of present ice bills. This AJAX Electric Iceman can be tucked away under the counter or in tight spaces . . . where no other "on-premise" icemaker will fit.

For installation on present ice storage cabinet, this AJAX icemaking unit can be bought by itself . . . saving money . . . saving space.

Manufactured by Servel, Inc.



Icemaker on present storage cabinet



Here are other AJAX Models, for other requirements . . . making over two million pounds of ice every day, on the premises of satisfied owners. Model A5A-4 (left) capacity over 300 lbs. of ice cubes daily. Model AF150 (right) makes ice flakes instantly, up to 1500 lbs. capacity.

PIN THIS COUPON TO YOUR LETTERHEAD

Ajax Corp. of America — Dept. H
2509 Washington Ave. — Evansville, Ind.

Send full details on the new AJAX Electric Iceman Model A3W-1

Name..... Title.....

Would like to have information also about

☐ AJAX Electric Iceman Model A5A-4

☐ AJAX Electric Ice Flaker Model AF150

Mr. E. B. Peel, administrator of the

Award-winning

Henry C. Beck Co., General Contractor • Whitehead Electric Co., Electrical Contractor

Down in the deep South, one of the nation's finest examples of contemporary hospital planning and design rises against the Atlanta sky. This striking eight-story, 363-bed addition to the original Georgia Baptist Hospital (194 beds) has earned wide acclaim for its planning group. The American Institute of Architects has presented Awards of Merit to architects Stevens and Wilkinson for excellence of design and to the hospital's administrative executives for their help and cooperation.

Preston S. Stevens

James R. Wilkinson

Architects and Engineers

It's Day-Brite in the waiting rooms

It's Day-Brite in the laboratory

Georgia Baptist Hospital

another great American hospital with Day-Brite lighting

There is a growing awareness among hospital administrators of the important benefits they get from good hospital lighting.

Some 80% of a person's actions are eye-controlled. In the complex operation of a hospital, the staff is faced with many critical seeing tasks that demand accurate, clear vision. Good hospital lighting means faster, better staff performance . . . reduces mistakes and errors . . . keeps morale up and turnover down . . . eliminates fatigue and nervous tension due to eyestrain.

The general lighting in the Georgia Baptist Hospital could easily serve as a model for any administrator looking for a practical answer to a hospital lighting problem.

The entrance, lobby, Memorial Waiting Room and all corridors are lighted with Day-Brite "troffers." All-white Day-Brite Viz-Aids* are installed in the pharmacy and in all other waiting rooms. In the kitchen and supply rooms, Day-Brite all-white Day-Line* industrial units furnish a high level of illumination for comfortable easy vision.

And beyond the assurance of year-in, year-out quality lighting performance, the selection of Day-Brite lighting fixtures guarantees another *must* for any administrator — *minimum maintenance and operating costs.*

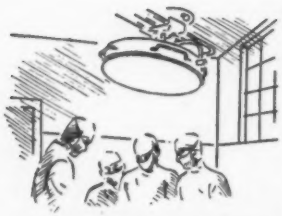
But perhaps the most significant approval of Georgia Baptist's lighting installation is included in the words of Administrator Peel . . . "We feel that this hospital is well planned from the standpoints of utility, economy, and appearance. We are greatly pleased with the results obtained."

Day-Brite can help you in your hospital, too. May we show you how?

*® 226

Day-Brite Lighting, Inc., 5455 Bulwer Ave., St. Louis 7, Mo. In Canada: Amalgamated Electric Corp., Ltd., Toronto 6, Ontario.

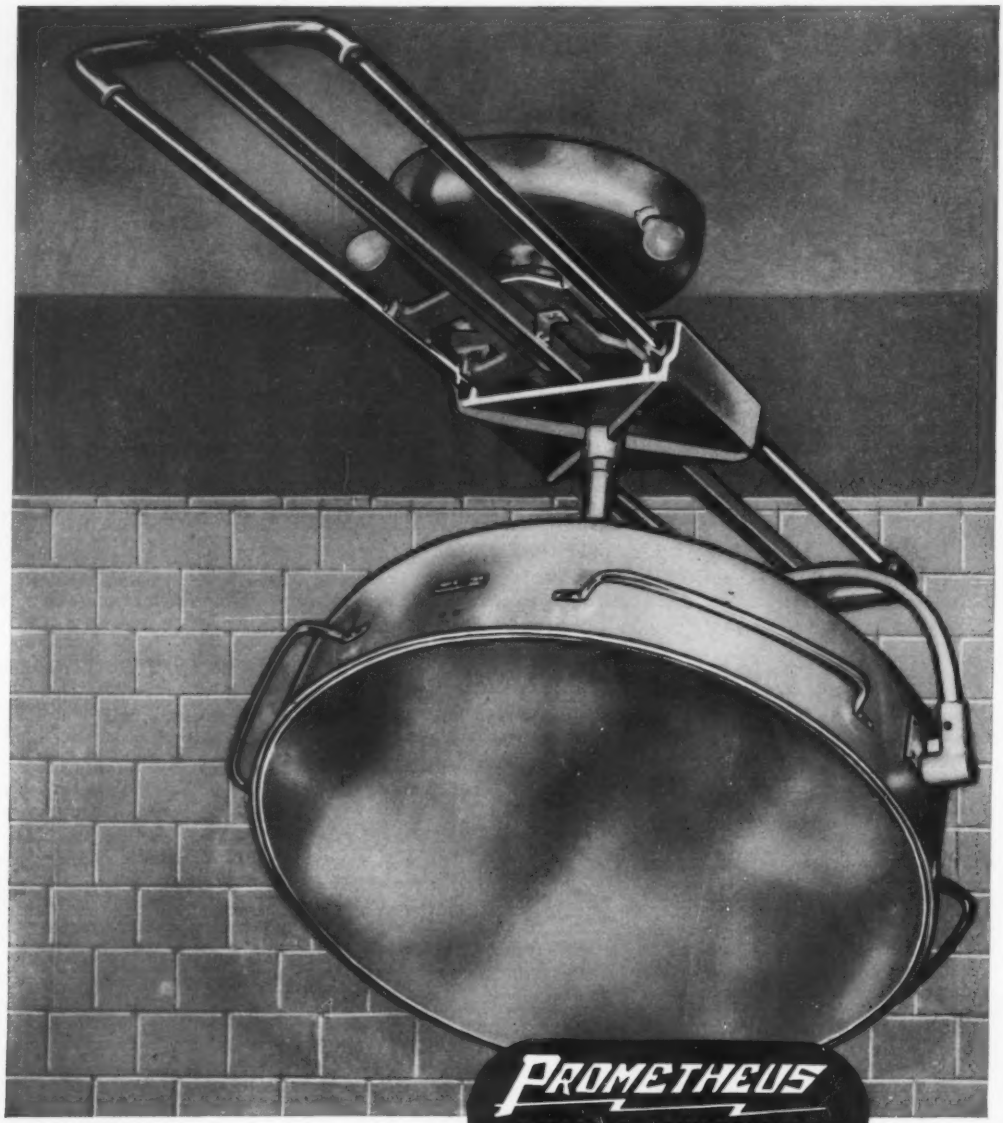
DECIDEDLY BETTER
DAY-BRITE
Lighting Fixtures



A new major Operating Light that eliminates "third rail" hazard!

This is the *only* major Operating Light that eliminates the "spark" hazard . . . a constant source of danger to both patients and personnel. An exclusive Prometheus feature puts an end to this problem. This light assures adequate lighting at the bottom of the incision.

Rotary track mounted, there is never any need to move operating table to bring the light into proper position for the operation, whether it be an appendectomy, mastectomy, cholecystectomy, etc. Special scientific filters provide heatless, shadow-free, color-corrected light.



Write for catalog of Prometheus Operating Lights, Sterilizers, Food Conveyors and other hospital equipment.

50 Webster Ave., New Rochelle, N. Y.

Full selection of Cones AT YOUR FINGER TIPS

Long or short, big or small, wide or narrow — Westinghouse has a cone for virtually every radiological need. We have deep, intermediate and superficial therapy cones, in dozens of shapes and sizes for dozens of applications. And every cone you buy from Westinghouse is precisely designed for accuracy of beam position, patient protection, field size, and other important factors.

Therapy accessories are as important to good results as the X-ray machine itself. In addition to cones, Westinghouse carries a complete line of filters, adapters, and localizers—all accepted as industry standards . . . all carefully designed and made with a precise knowledge of your radiological needs.

See your local Westinghouse representative for full information on cones. To obtain a complete listing of all Westinghouse X-ray accessories, write the Westinghouse Electric Corp., X-ray Accessories Section, 2519 Wilkens Ave., Baltimore 3, Md.

PORTABLE UNITS TUBESTANDS X-ACTRON WESTLINE CABINETS MONOFLEX PFX FLUORADEX DUOCONDEX SERVICE ACCESSORIES

YOU CAN BE SURE... IF IT'S

Westinghouse

MEDICAL X-RAY

J-90256

POLAR WARE

stainless steel Bed Pan

A catalog showing the complete Polar Ware line is yours for the asking.

a long return on a small investment

GRANTED that a bed pan is a bed pan — there's still a difference in your favor between the service potential of stainless steel Polar Ware and others.

Take hold of a Polar Ware pan. You'll notice at once that it "feels" stronger, more rugged. And it *is* more rugged . . . made of heavier gauge stainless steel that will still be in every-day use long after ordinary lighter gauge pans have been replaced.

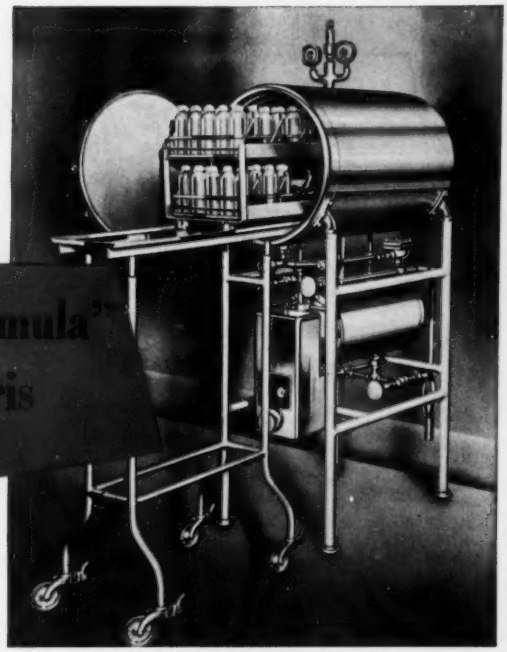
It's good to know, too, that the most advanced welding process makes this better bed pan in one solid piece. The inside has a satin-smooth surface. There is no area that can harbor bacteria, no concealed section that ordinary aseptic methods will not make sterile.

In large and small hospitals everywhere, the economical, trouble-free performance of this Polar Ware pan is being proved every hour of the day. You, too, will find it premium in everything but price. Ask the men who call on you. The best of them carry Polar Ware.

Polar Ware Co.

4300 LAKE SHORE ROAD · SHEBOYGAN, WISCONSIN

What's the "basic formula" for this Scanlan-Morris sterilizer?



SCANLAN-MORRIS Milk Formula Sterilizer features inner chamber, bottle basket and racks of rugged, corrosion-resisting Monel. Cylindrical sterilizers are available in several standard sizes for operation by electricity, steam or gas. Rectangular models with Monel-clad Steel interiors are also available in several sizes for direct steam heat only. These can be supplied with Monel loading cars of either basket or solution type.

There is a one-word answer to that question.

You probably know the word, too.

It's MONEL® — the "basic formula" behind a sterilizer designed to withstand heat . . . pressure . . . fatigue . . . water . . . steam . . . hospital solutions.

Yes, Monel does all this—and does it well. For in Monel you have an unusual, long-wearing Nickel Alloy. Stronger and tougher than structural steel, it is easily capable of withstanding sterilizing pressures.

What's more, it won't rust, and is highly resistant to corrosion and staining. Being solid, Monel gives your sterilizers *life-time protection* against chipping, crazing or peeling.

This protection, of course, never ends because it never wears away. With Monel, the "surface" actually extends through the *full thickness* of the metal!

Keeping a Monel sterilizer bright, shiny and new-looking isn't an all-day job, either. Ordinary soap and plain, warm water are usually all you need. Or you can scrub Monel with mildly abrasive cleansers or detergents as often as you think necessary. No matter how hard you tried, you wouldn't be likely to scrub away Monel's good looks—*they're permanent.*

Add up all these advantages, and you can see why the OHIO CHEMICAL & SURGICAL EQUIPMENT COMPANY makes Monel construction available in their Scanlan-Morris milk formula sterilizers, cylindrical pressure-type surgical supply sterilizers, instrument sterilizers, and water and solution sterilizers.

For full information about Scanlan-Morris Monel-equipped sterilizers, write OHIO-CHEMICAL & SURGICAL EQUIPMENT COMPANY, A Division of *Air Reduction Company, Inc.*, 1400 E. Washington Ave., Madison 10, Wisconsin.

Remember, though, that Monel is on "extended delivery" because so much is taken for defense. By placing orders well in advance, you'll improve your chances of getting delivery of your Monel-equipped sterilizers when you need them.

EMBLEM OF SERVICE INCO

THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street, New York 5, N. Y.

Monel... *always a name to remember*

5 REASONS WHY IT'S YOUR BEST BUY!

UNIVERSAL INDIVIDUAL Beverage Server

Use has proved its value

10 oz. capacity
VB 8390
20 oz. capacity
VB 8392

1. EFFICIENCY – Cold coffee or tea means irate patients! A Universal Individual Beverage Server is a genuine *Thermal* Server that keeps beverages piping hot to the last delicious and refreshing sip . . . assures your patients of complete satisfaction.

2. ECONOMY – A Universal Individual Beverage Server costs no more than an ordinary pot and soon pays for itself in reduced replacements. It is sturdy and durable. However, if through abuse the inside plastic filler has to be replaced, "it's as simple as changing a light bulb," and almost as inexpensive.

3. CLEANLINESS – All seams of the Universal Individual Beverage Servers are air-tight, water-tight and are never affected by live steam. Wide mouths make them easy to keep clean and sterilize.

4. APPEARANCE – Universal Individual Beverage Servers are finished in chrome-plate and are easily etched or engraved. Its rich and attractive design adds a note of luxury and refinement to your service.

5. EASY UPKEEP – Universal Individual Beverage Servers are easily cleaned and sterilized without constant fear of breakage. A damp cloth is all that is needed to keep the exterior shining and lustrous.

Write for full information today!

UNIVERSAL

LANDERS, FRARY & CLARK, NEW BRITAIN, CONN.

FACTS: • CERTAIN FOODS "STORE" • BETTER WITH "DRY" HEAT;— AND CERTAIN FOODS DEMAND "MOIST" HEAT

BUY **SECO*-MATIC** *and* ***get both!***

*Trade Mark Reg.

DRY OR MOIST
SECO-MATIC
DRY MOIST

DRY OR MOIST CIRCULATING HEAT — CONVERTIBLE — COMBINATION FOOD SETTING

HOT FOOD TABLE

PATENT APPLIED FOR

Showing 5-opening Gas; Enclosed Base, Sliding Doors; with Glass Protector Guard and S. S. Shelf.

12 Basic Gas or Electric Models; 2 to 7 top openings; Open, Semi, and Enclosed Base

ALL MODELS A. G. A. OR U. L. APPROVED

Yes . . . SECO-MATIC HOT FOOD TABLES are the answer to BOTH types of HEAT—Either "Dry-or-Moist" heat . . . convertible or combination—and ALL from the SAME table operation . . . with the TYPE OF REGULATED Sectional heat BEST SUITED for EACH food!

ANNOUNCING

YOUR KEY TO... GREATER COFFEE CAPACITY

SECO*-URNS are SQUARE inside and out—offering Up to 50% GREATER COFFEE AND WATER CAPACITY**—Utilizing every inch of MINIMUM stand or counter space!

**Over Conventional Round Liner Twin Urns

DIE-STAMPED STAINLESS STEEL

SQUARE TWIN COFFEE URNS

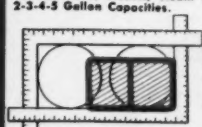
NON-PRESSURE NON-SYPHON SEAM WELDED

SECO TWIN SPACE SAVER URN

TRADE MARK REG.

Showing 5-Gallon Electric, with Thermostatic Heat Control and Hot Water Temperature Gauge.

12 Basic Gas, Electric, Steam Models; 2-3-4-5 Gallon Capacities.



More Coffee served in LESS Space at LESS Cost!

MAIL TODAY FOR NAME OF NEAREST SOUTHERN DEALER

BUDGET PRICED

- ☐ Send SECO-MATIC Catalog SDM-6850 b
- ☐ Send SECO-URN Catalog STU-50 B
- ☐ Have Representative Call

Name.....

Address.....

City.....Zone....State.....

Attention.....

Test Series Adv. T/P-2

SOUTHERN EQUIPMENT CO. *Custom-Bilt by Southern* 5017 S. 38th ST. LOUIS 16, MO., U.S.A.

PORTION CONTROL!

KRAFT PC* PACK

*PORTION CONTROL

individual jams and jellies

Kraft PC Pack . . . individual servings of top-quality jams and jellies in sealed plastic containers . . . steal the show at National Restaurant Convention

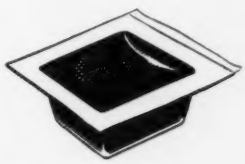
Here are individually sealed jam and jelly portions—specially designed for hotels and restaurants. Actually tried, tested and acclaimed by hotels, restaurants, airlines and railroads.

- *Accurate portion control* . . . exact measure.
- *Perfect inventory control* . . . you know the exact number of servings on hand.
- *Measured costs* . . . No time and labor involved in preparation for serving.
- *Uniform high quality* . . . delicious, pure fruit jams and jellies.
- *Complete sanitation* . . . special plastic containers completely sealed with transparent vinylite.
- *Customers like them* . . . they're served with a nicety that is entirely new.

If you haven't seen PC's, call your Kraft Institutional representative today. You, too, will be singing praises for PC's.

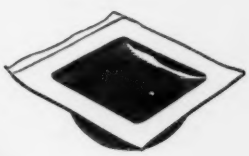
See your Kraft institutional representative for the new price schedule for each variety.

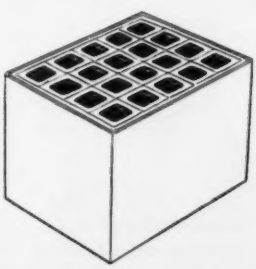
2 SIZES TO FIT YOUR NEEDS



¾ OUNCE SIZE makes a generous serving.

½ OUNCE SERVICE is an adequate amount for the average service.





PACKED 200 TO THE BOX PC's are conveniently packed in trays of 20 . . . 10 trays to the box. Easy to store . . . take little space and no refrigeration.

Distributed direct and through service-minded jobbers everywhere **BULK AND PORTION NATURAL CHEESES (imported and domestic)**

PASTEURIZED PROCESS CHEESES • CREAM CHEESES • GRATED CHEESES • KRAFT KITCHEN FRESH MAYONNAISE

MIRACLE WHIP SALAD DRESSING • KRAFT FRENCH AND MIRACLE FRENCH DRESSINGS • CUISINE SALAD DRESSING

SEA ISLAND DRESSING • MUSTARDS • HORSERADISH • SALAD OIL • PARKAY MARGARINE • MALTED MILK

a complete line without a break...

so substantial, yet so much lighter than you think!

CONSERVES THE ENERGY OF HOSPITAL PERSONNEL

DELIGHTS PATIENTS AND PERSONNEL ALIKE

EASES THE LOAD IN THE KITCHEN

Mix or Match:

POWDER BLUE
GOLDEN YELLOW
SEA FOAM GREEN
TAWNY BUFF
STONE GRAY
FOREST GREEN
CRANBERRY RED

Look at BOONTONWARE — at its style and solidity — and you say, ***"How attractive."***

But pick it up — and you say, ***"Amazing."***

Nothing odd, nothing bizarre, nothing less than substantial to the sight and touch — yet it is less than half as heavy as ordinary dinnerware.

BOONTONWARE is the fashioning of Melmac® at its best.

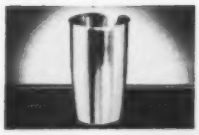
See your regular Supply House or write to us for the name of your nearest Dealer.

Boontonware complies with CS 173-50, the heavy-duty melamine dinnerware specification as developed by the trade and issued by U. S. Department of Commerce, and conforms with the simplified practice recommendations of the American Hospital Association.

Boontonware

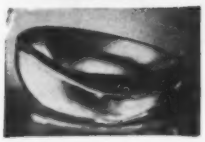
fine dinnerware fashioned of MELMAC®

BOONTON MOLDING COMPANY, Boonton, New Jersey



Look to this trusted trademark for Long-Established Dependability in a Choice of Utensil Lines

ORIGINAL AND EXCLUSIVE MANUFACTURERS OF VOLLRATH WARE
VOLLRATH
SINCE 1874
TRADE MARK
REG U S PAT OFF
THE VOLLRATH CO. SHEBOYGAN, WISCONSIN, U.S.A.



There is no finer or better-built equipment than Vollrath Stainless Steel Ware—designed to meet every requirement for sanitation, efficiency, and distinguished durable service. All items in this complete institutional line are fully seamless and entirely machine-finished to demanding specifications for hospitals, restaurants, and government use. Every piece has the finest custom polish.

Vollrath also serves all institutional departments with a Budget-Priced line of Porcelain Enameled Steel Ware. Practical, pure and dependable for commercial use—surpassing standards approved by the U. S. Bureau of Standards—these seamless utensils have a smooth and uniformly-coated bright finish in Vollrath's advanced Titanium White for enduring acid resistance and cleanliness.

Only The Vollrath Company offers this alternate choice of institutional ware—all made in a modern plant with progressive manufacturing methods including first quality workmanship and inspection through all operations—and backed by leading quality standards gained from experience in the manufacture of utensils since 1874.

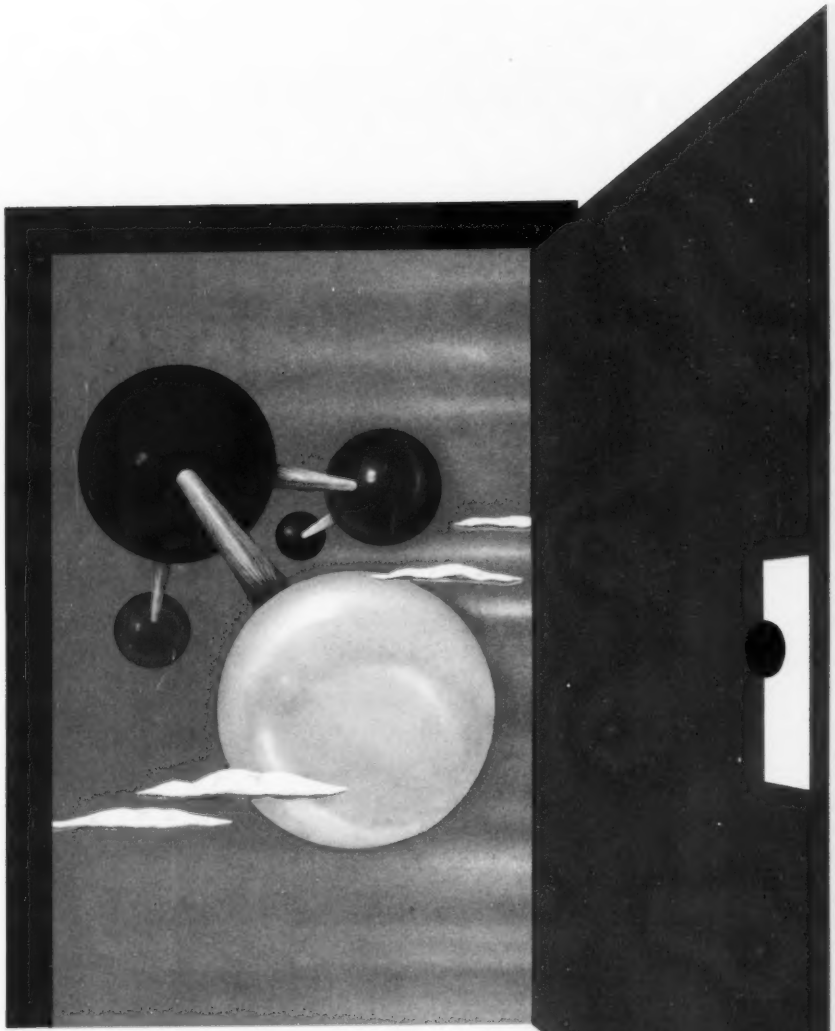
Look to your Vollrath Jobber, foremost in the field, for your choice of utensils in Vollrath Ware.

The **Vollrath Co.**
SHEBOYGAN, WISCONSIN

Branch Offices and Display Rooms

NEW YORK CHICAGO LOS ANGELES

This brochure, "The Manufacturing Story behind Vollrath Quality Products," is a picture-trip through the vast Vollrath plant. You'll see the diversified facilities and skills that fabricate metal products of highest quality. Write us for a copy.



Opening the door to . . .

INCREASED CARBOHYDRATE ALIMENTATION

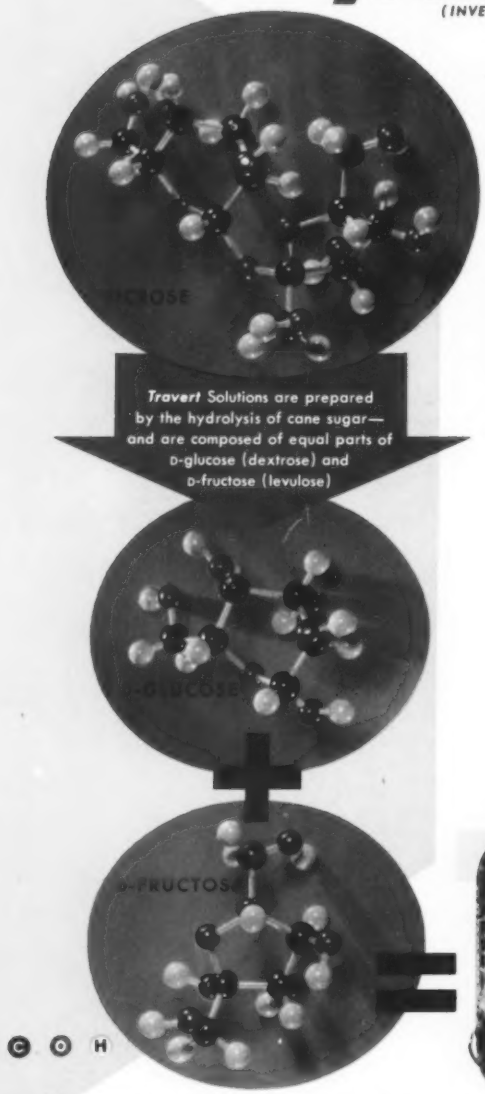
10% Travert® SOLUTIONS

(INVERT SUGAR)

- *for twice the calories of 5% Dextrose*
- *in equal infusion time*
- *with no increase in fluid volume*

10% *Travert*® SOLUTIONS

(INVERT SUGAR)



—the first major improvement in parenteral carbohydrate therapy since dextrose

- **Provide twice as many calories as 5% dextrose**
- **In equal infusion time**
- **With no increase in fluid volume or vein damage**

Until recently, the limited rate of dextrose utilization has made it impractical to administer adequate carbohydrate for many patients. New ***Travert*** Solutions help overcome this difficulty.

Travert Solutions are utilized more rapidly at similar or at greater rates of infusion than dextrose. A liter of 10% ***Travert*** Solution (400 calories) requires no more time for administration than a liter of 5% dextrose (200 calories)—yet the patient gets twice as many calories!

*10% **Travert** Solutions are available in water or saline in 150 cc., 500 cc., 1000 cc. sizes.*

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Prescribe Travert

1. *to provide nutriment quickly*
2. *to spare protein by minimizing protein catabolism*
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best on the business end of bumps

Chances are that the wainscoting in your corridors bears the scars of many a bump by wheel chairs, stretchers, carts and wagons. MICARTA® can prevent these costly traffic accidents because this incredibly tough laminated plastic resists scuffs, scars, chips and dents. What's more, MICARTA's smooth sanitary surface remains practically maintenance free. That's why more and more hospitals are considering economical, super-tough MICARTA for wainscoting and other traffic-bearing surfaces.

Beautiful, easy-to-clean MICARTA comes in many patterns and many colors to harmonize with the pleasant, efficient color scheme of your hospital.

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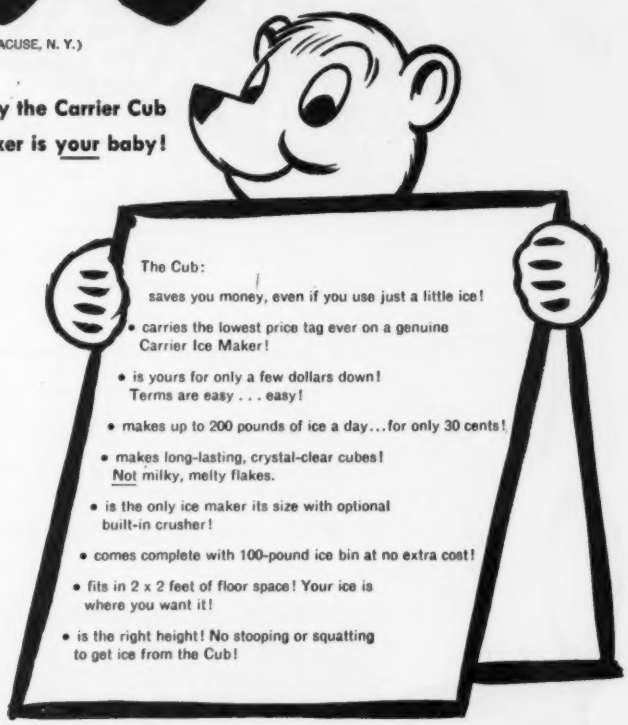
MH-6-52


it's a blessed event!

$699 buys this new Carrier Cub Ice Maker

(F.O.B. SYRACUSE, N. Y.)

Here's why the Carrier Cub Ice Maker is your baby!



Even if you buy less than 100 pounds of ice a day . . . you can save money with this new Carrier Cub Ice Maker. Figure it out for yourself! You can make 100 pounds of ice with the Carrier Cub for only 15 cents! How much are you paying? How much can you save?

Own a Cub and you put that money in your pocket . . . not the iceman's! But don't wait! Call your Carrier dealer today! You'll find him listed in the Classified Telephone Directory. The sooner you call, the more you'll save! Carrier Corporation, Syracuse, New York.

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Don't forget the big model! It'll save you money if you use over 200 pounds of ice a day. It makes up to 450 pounds a day and it is also available with a built-in crusher.

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really DISPOSABLE!

It's not just a name . . . the
B-D DISPOSABLE BLOOD DONOR SET
is *inexpensive enough* to be used once and
discarded. No cleaning, no sterilizing, no reassembling,
no danger of pyrogens . . . and it offers six important advantages:

1 Needles and tubing have same inside diameter, permitting unobstructed flow of blood at steady rate in a vein-like environment, minimizing turbulence.

2 Smaller intravenous needle for greater comfort to donor.

3 A new, sharp needle is used for each donation . . . no needle is used a second time.

4 System is self-regulating, requires no control mechanism to govern flow of blood.

5 Smaller stopper-puncturing needle minimizes plug cutting of rubber.

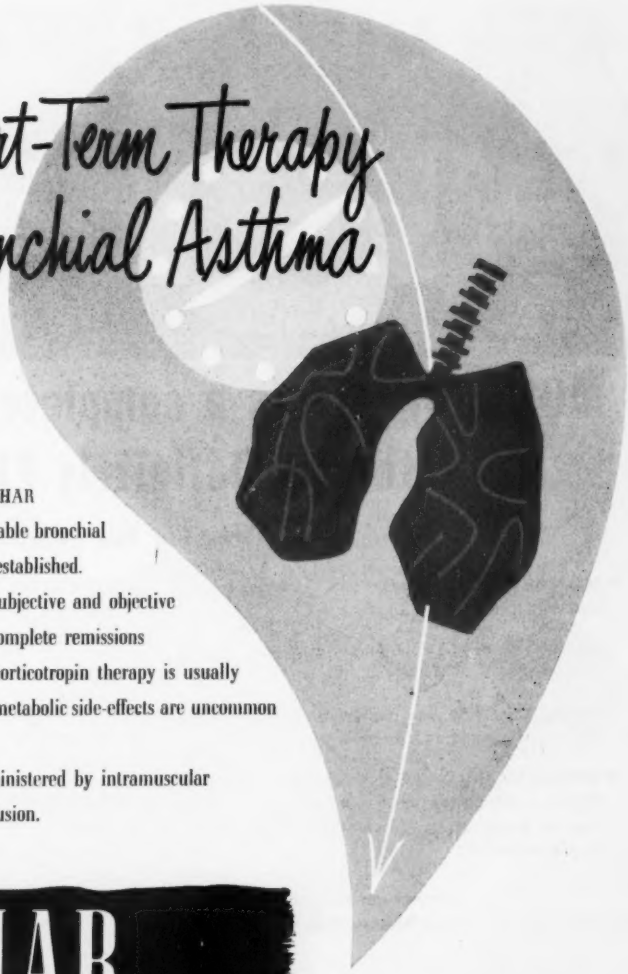
6 Unique holder-clamp not only provides shut-off for tubing, but also makes possible two-hand, counter-balanced method of inserting and withdrawing stopper-puncturing needle.

The B-D DISPOSABLE BLOOD DONOR SET is supplied sterilized, pyrogen-free, ready for use, individually packaged, in cartons of 50 sets with 2 holder-clamps per carton.

BECTON, DICKINSON AND COMPANY
RUTHERFORD, NEW JERSEY

B-D, TRADEMARK REG. U. S. PAT. OFF.

A New Short-Term Therapy of Acute Bronchial Asthma



The significant contribution made by ACTHAR in the short-term treatment of acute intractable bronchial asthma and status asthmaticus is firmly established. The action of ACTHAR is rapid; marked subjective and objective improvement is noted within hours, and complete remissions have been observed in 2 days. Prolonged corticotropin therapy is usually unnecessary in this disease and, therefore, metabolic side-effects are uncommon due to the small total dose required.

ACTHAR Powder (Lyophilized) can be administered by intramuscular injection or by continuous intravenous infusion.

ACTHAR

The Armour Laboratories Brand of Adrenocorticotropic Hormone — ACTH (Corticotropin)

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ACTHAR Powder (Lyophilized) is available in vials of 10, 15, 25 and 40 U.S.P. units (I.U.).

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world-wide dependability

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

MONARCH offers a complete dressing line that is Definitely FINER!

A Salad Dressing For Every Need

- **MONARCH Mayonnaise** has a combined egg and oil content of 87%.
- **MONARCH Salad Dressing**—minimum oil content of 35%.
- **MONARCH Thousand Island Dressing**—one of the most popular in this most popular line.
- **MONARCH Combination Dressing**—a truly different combination of mayonnaise and Russian that is tantalizingly different for fruits and for vegetable salads.
- **MONARCH Roquefort Cheese Dressing**—so perfectly homogenized that it retains its lusty Roquefort taste to the last delicious spoonful.
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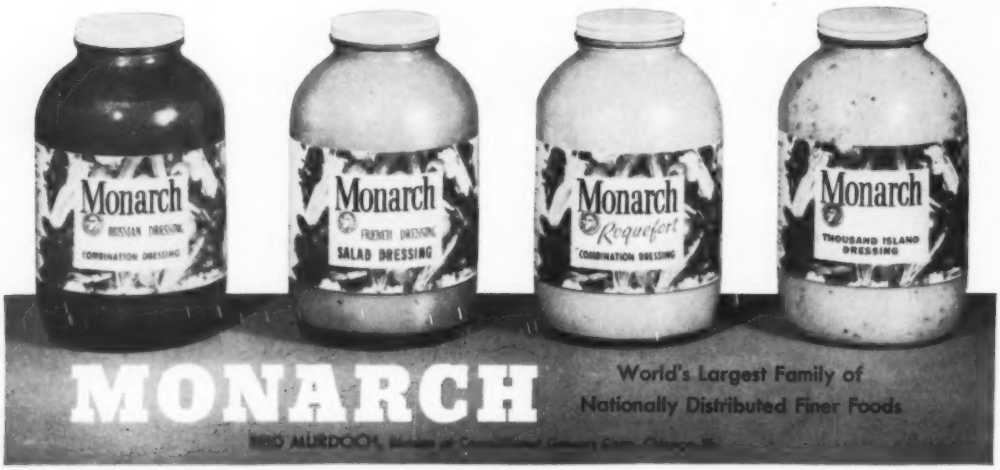
- **MONARCH French Dressing**—perfectly emulsified—will not separate.
- **MONARCH Dill Dressing**—a different dietary delight, perfect for salads, fish and meat . . . has that real dill flavor.

Summer months are salad months. Use MONARCH dressings and insure your Summer Salad Success. Packed in Institutional and smaller sizes.



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in LAMINATED TRAYS

COLOR is magic in creating a setting for foods! For that last "finishing touch" to your decor, nothing equals BOLTA LAMINATED TRAYS . . . designed in 36 combinations of color to meet every decorative matching or contrasting possibility. Their eye-appeal makes meals more appetizing whether self-served or French-served. All this and durability, too! The cost? Only a few cents more per tray! . . . and you save in the long run because BOLTA Laminated Trays give you years of extra wear.

Also Famous Boltalite Hard Rubber Trays in Sizes 10x14, 12x16, 14x18 and 15x20. Also Boltabilt Trays in Round, Oblong and Oval Shapes, in 15 different Sizes.

COLOR adds *business*... **BOLTA** adds *color*

Only BOLTA has perfected the techniques that make possible this combination of laminated patterned color and outstanding durability.

- In sizes 12x16, 14x18 and 15x20
- Non-porous, Satin-smooth Surfaces
- Impervious to Cigarette Burns, Food Acids, Alcohol, Fruit Juices
- Lightweight, Noiseless, Easy to Handle
- Washable in Mechanical Dishwashers
- Will not Break, Warp, Fade, Spot or Split

The BOLTA *Company*
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Planning to Re-decorate? Specify BOLTAFLEX *and* BOLTA-QUILT *for furniture and paneling*

This hospital floor will look like new for years!

This glowing, colorful installation in the West Side Hospital, Scranton, Pa. will have a clean bill of health . . . easy to walk on, easy to look at, easy to keep that way!

GOLD SEAL
TRADE-MARK®
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GOLD SEAL NAIRN LINOLEUM

. . . satisfaction guaranteed!

You're looking at the one floor covering that's designed and built to take, and *laugh off* the roughest, toughest use imaginable. The floor that *stays* beautiful, bright, and quiet for years on end . . . that keeps right on looking brand new with an absolute minimum of care. You're looking at the one and only Gold Seal Nairn Linoleum . . . backed by the strongest money-back guarantee in the business!

With Gold Seal Nairn Linoleum, you've got *the* floor, and you've got it *for good*, with *long life . . . enduring beauty . . . easy maintenance . . . true resilience . . .* and the good-as-gold Gold Seal guarantee of *complete satisfaction or your money back!*

The Gold Seal is your money-back guarantee of satisfaction from the makers of the finest floor coverings in the world:

GOLD SEAL NAIRN LINOLEUM
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GOLD SEAL VINYL INLAIDS

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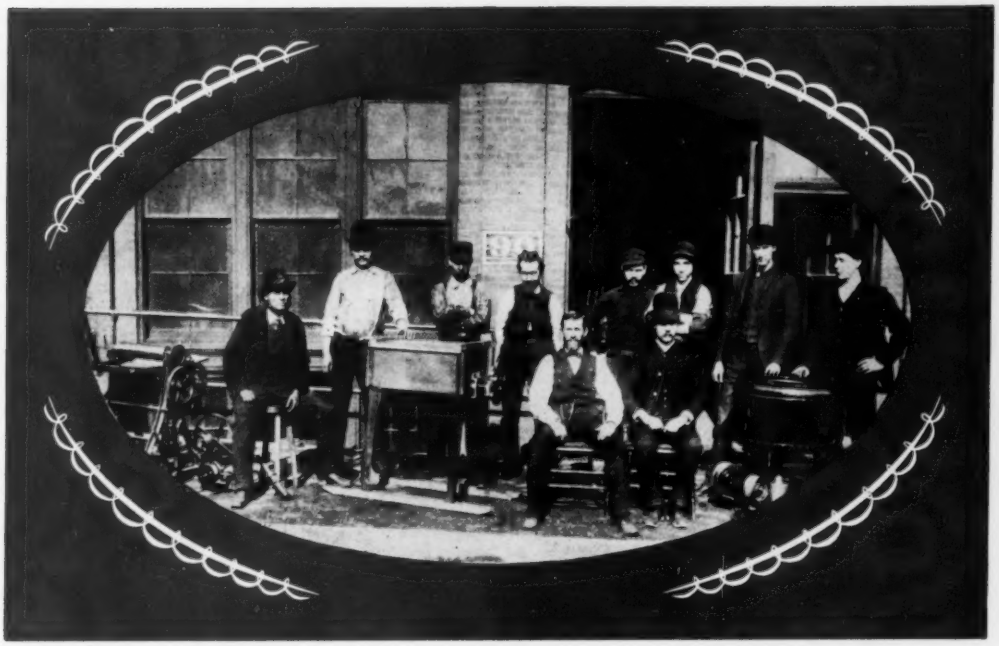


a picture from our "FAMILY ALBUM"

More than 80 years ago, the men pictured above built the machines that were the forerunners of the modern, high-production laundry equipment which now proudly bears the "AMERICAN" trademark. From a background of experience begun in 1868, has come a heritage of skilled workmanship which guarantees the dependability and superior performance of every machine produced by our Company's modern factories today.

Through the years, constant research and painstaking development by AMERICAN's engineers has perfected an outstanding line of laundry equipment designed for hospitals of every size. And back of every AMERICAN installation is more than 80 years of experience in planning and equipping laundry departments for thousands of hospitals all over the world.

That is why approximately 95% of the leading hospitals and institutions today have AMERICAN-equipped laundry departments . . . every one of them benefiting by our Company's *heritage of experience.*

In new AMERICAN-planned laundry department at 225-bed Glendale Sanitarium & Hospital, Glendale, Calif., these CASCADE Unloading Washers with Automatic Washing Controls are typical of the high-production, labor-saving equipment installed.

The
AMERICAN
LAUNDRY MACHINERY CO.
CINCINNATI 12, OHIO

Appliances and Equipment for Fracture Treatment Supplied by Zimmer

When surgical progress calls for a new fracture splint, a new type of bone screw or a bed lifter, Zimmer answers the call with equipment designed especially for the immediate need.

Among the newer Zimmer equipment is the much improved Patient Helper, illustrated to the right. This Helper may be rotated into position and locked or left swinging free. The height is adjustable, and models are made to fit every type of bed.

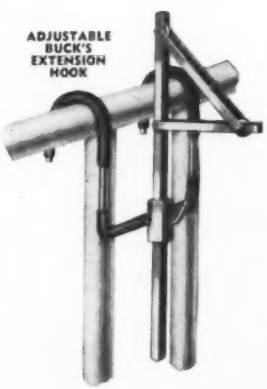
Other Zimmer equipment is often far in advance of popular demand, placing Zimmer in a position of leadership that would be impossible were it not for the confidence and support of America's most successful bone surgeons.

ZIMMER MANUFACTURING COMPANY, WARSAW, INDIANA

ADJUSTABLE PATIENT HELPER

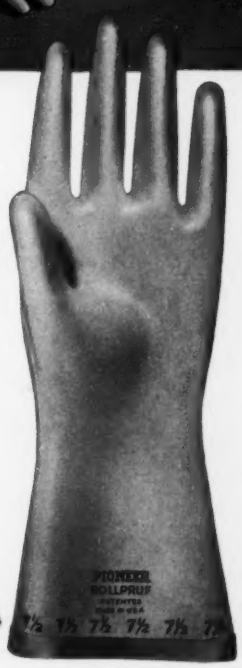
ZIMMER BED-LIFTER IN USE

ZIMMER BED-LIFTER



ADJUSTABLE BUCK'S EXTENSION HOOK

Zimmer
MANUFACTURING CO. WARSAW, IND.



Specify Quality Surgical Gloves WITH Multi-Size Markings

by PIONEER

7½ 7½ 7½ 7½ 7½ 7½ – size is printed in a row across the cuff – easily visible in any pile. Speeds up sorting, reduces labor costs. Of highest grade virgin latex, doctors and nurses everywhere prefer their greater sensitivity. Beadless flat-banded Rollprufs won't roll down during surgery. Longer-wearing, they cost less in the long run! Order today from your wholesaler or write us.

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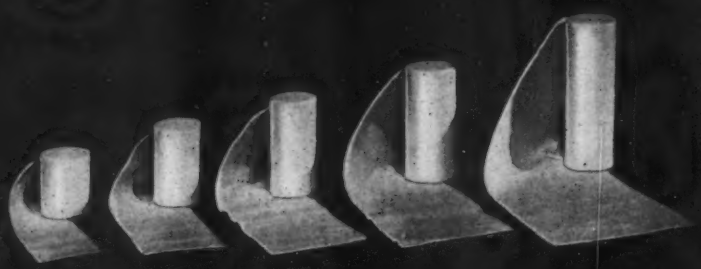
750 TIFFIN ROAD • WILLARD, OHIO

TIME-SAVING ORTHOPEDIC

for dependable

New *protective* dispensing-box for each size of "Specialist"* Orthopedic Stockinet solves storage and handling problems.

Five convenient sizes of Belleview* Surgical Wadding in *ready-cut* rolls save costly time and labor of cutting and rolling by hand.



"Specialist"* Splints (ready-cut lengths of "Specialist" bandage material) replace hand-folded "reverses"—facilitate rapid splinting and cast-reinforcement. Three handy sizes: 3" x 15", 4" x 15" and 5" x 30".

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PRODUCTS

plaster casts . . .

"Specialist"® *Extra-Fast-Setting* Bandages (2 to 4 minute setting-time) are ideal for the doctor who prefers an extremely fast-setting bandage for club-foot, wrist, or other types of cast work. (Green label identifies "*Extra-Fast-Setting*").

(Green Label)

(Blue Label)

"Specialist"® *Fast-Setting* Bandages (5 to 8 minute setting-time) are the standard of choice in most hospitals for all general cast work. (Blue label identifies "*Fast-Setting*").

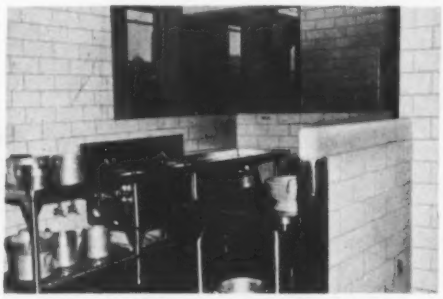
"Specialist"® *Slow-Setting* Bandages (10 to 18 minute setting-time) permit more molding and finishing of large body and spica casts before plaster commences to set. (Gray label identifies "*Slow-Setting*").

(Gray Label)

ORTHOPEDIC DIVISION

Johnson & Johnson

New Brunswick, N. J. Chicago, Ill.



BETH-ISRAEL HOSPITAL ADDITION, BOSTON, MASS.
Archts.—Curtis and Riley. Contrs.—Volpe Constr. Co.

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Hospital interior views above show use of NATCO Ceramic Glazed Vitritile for walls

NATCO
QUALITY CLAY PRODUCTS SINCE 1889

IN HOSPITALS EVERYWHERE

NATCO Ceramic Glazed Color Engineered VITRITILE

In all of the hospitals pictured above, Natco Ceramic Glazed, Color Engineered Vitritile was selected for interior walls and partitions for color and finish, because it solved such definite hospital needs and problems as good visibility, relief from eye strain, fatigue, convalescence, etc.

In addition to being the right colors for hospital interiors, walls and partitions of Natco Ceramic Glazed Vitritile will stand up under hard usage, give the utmost in sanitation, are proof against rodents, vermin and bacteria — are easily cleaned and kept clean with ordinary soap and water.

Designed for either modular or conventional design, Natco Ceramic Glazed Vitritile with its complete line of shapes and co-ordinated fittings is completely adaptable to desirable and efficient layout design, with a minimum amount of cutting and fitting.

Write for additional information on Natco Ceramic Glazed Vitritile, also for literature describing other Natco Structural Clay Products for use in **every type of building construction.**

THE PRODUCERS' COUNCIL

FTI Member of Facing Tile Institute

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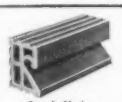
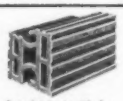
"The Quality Line Since 1889"

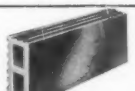


Raggle Blocks
Prevent Water Seepage
4" x 5⅓" x 12" Nom. Size



Speed-A-Backer Tile for
Backing Brick Faced Walls
12" long Varying Heights

Ceramic, Clear
Glazed Vitritile 5⅓" x 12"
Nom. Face Size



Ceramic Glazed Vitritile
8" x 16" Nom. Face Size

Non-Loadbearing Tile, Scored
and Unscored, 12" x 12" Face
In Standard Wall Thicknesses

Buff Unglazed, Manganese
Spot, Salt Glazed, Red
Textured Dri-Speedwall Tile,
5⅓" x 12" Nom. Face Size

Small Hospital Questions

How Much for Special Diets?

Question: What per cent of hospitals charge for special diets? How much do they charge? And how much personal attention on the part of the dietitian does that imply? —R.H.W., Iowa

ANSWER: One of the great economic mistakes made in hospitals through the years and one which fortunately is now being corrected by many of the better hospitals is the setting of the daily room, food and service rate for patients far below cost and then making up this cost by excessive charges in the laboratory, the x-ray department, and so on. The more thoughtful and far-seeing hospital executives are now basing all charges for the public starting with the actual cost for the service.

Few hospitals in this country (in fact, I don't know of any) charge for special diets. The daily service charge, called by many the room rate, should of course include high enough rates to cover all special diets. It has always seemed to many people in the hospital field that another mistake made by many hospitals is the charging for many small items which really could be called a nuisance charge. It is far better to eliminate all these small charges and include them in the one daily rate.

No one could really answer how much personal attention the patient should get from the dietitian. The only answer to this is that the patient must have enough attention and time from the dietary department to meet the medical, dietary and nutritional needs of that patient.—E. W. JONES.

Untangling Surgical Masks

Question: Do you know of any satisfactory method for handling masks and other small items in the hospital laundry so that these do not become entangled with other pieces, causing time losses for sorting?—F.W., N.J.

ANSWER: We recently completed a test of different methods, trying to find one which would prevent the hospital masks from becoming tangled in the laundry washing process. As any hospital laundry manager knows, when these masks become tangled it is difficult to separate them for processing and much time is consumed in the attempt.

Our method is quite simple, but nonetheless saves the department considerable time. When the washman receives the masks from the floors, he places them in a mesh laundry net and then, instead of pinning the net across the top, which is the commonest procedure, he pins the net down close to the masks. For example, if the net were half full he would then pin the net midway down. This prevents the masks from moving around as much in the washing process, and thereby eliminates most of the tangling.—DUANE E. YOUNG, *laundry manager, Mount Sinai Hospital, Minneapolis.*

Roentgenologist's Percentage

Question: What is the usual percentage fee paid to roentgenologists?—R.H.W., Iowa

ANSWER: There is no one percentage of hospital charges for radiology service going to the radiologist. By and large, the principle followed is that neither the radiologist, the hospital nor the patient shall be exploited. Some hospitals pay their radiologists on a straight salary basis, and this salary is often changed from year to year on the basis of the volume of net earnings in the department. A recent report indicated that 37 per cent of radiologists in hospitals are on salary; 54 per cent are on a percentage basis, and 9 per cent are on a rental arrangement.

However, the commonest method of paying the radiologist is to guarantee the radiologist a flat minimum salary and then add a percentage of the net income of the department.

One good way to calculate the radiologist's compensation would be to calculate all expenses of the department, and this, of course, would include an allocation of all administrative overhead, an allocation of charges for the space occupied, allocation of depreciation on radiological equipment of either 12 or 15 per cent, allocation of depreciation on all other equipment at a 3 or 4 per cent rate per year, allocation of depreciation on the value of that part of the building occupied by the department, plus, of course, all direct expenses. This amount of money subtracted from the actual cash income of the department would give the net income to be divided between the hospital and the radiologist. This is often divided on the basis of 50 per cent to each, or in some cases 60 per cent goes to the radiologist and 40 per cent to the hospital.—E. W. JONES.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Precautions With Paints

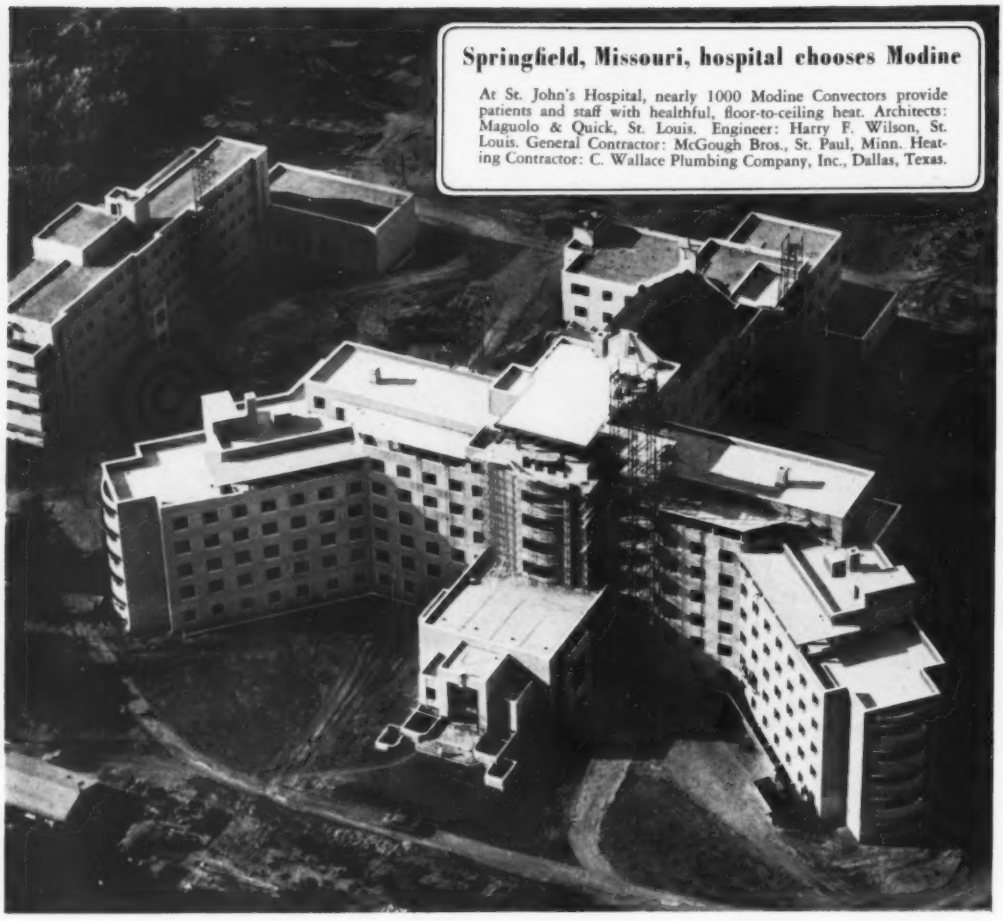
Question: What precautions can be taken to avoid the fire hazards inherent in paints and various cleaning materials?—V.J., Ala.

ANSWER: Many of the cleaning and painting materials used in hospitals are of an inflammable nature; it is extremely important to be careful in their storage and use. Useful information on this subject is included in the publication F. P. File M60, revised as of Oct. 30, 1950, published by the National Board of Fire Underwriters. This publication can be obtained from the board by writing to its headquarters at 85 John Street, New York City.

Fire Extinguishers

Question: What are the principal types of fire extinguishing agents for use in hospitals? —W.R.K., Ariz.

ANSWER: For a complete answer to this question, we suggest you write the National Board of Fire Underwriters, Committee on Fire Prevention and Engineering Standards, 85 John Street, New York City, and ask for F.P. File M32 covering fire extinguishing agents. Bulletin No. 53 gives a complete discussion of fire fighting agents and should be available to all hospital administrators and their chief engineers.



Springfield, Missouri, hospital chooses Modine

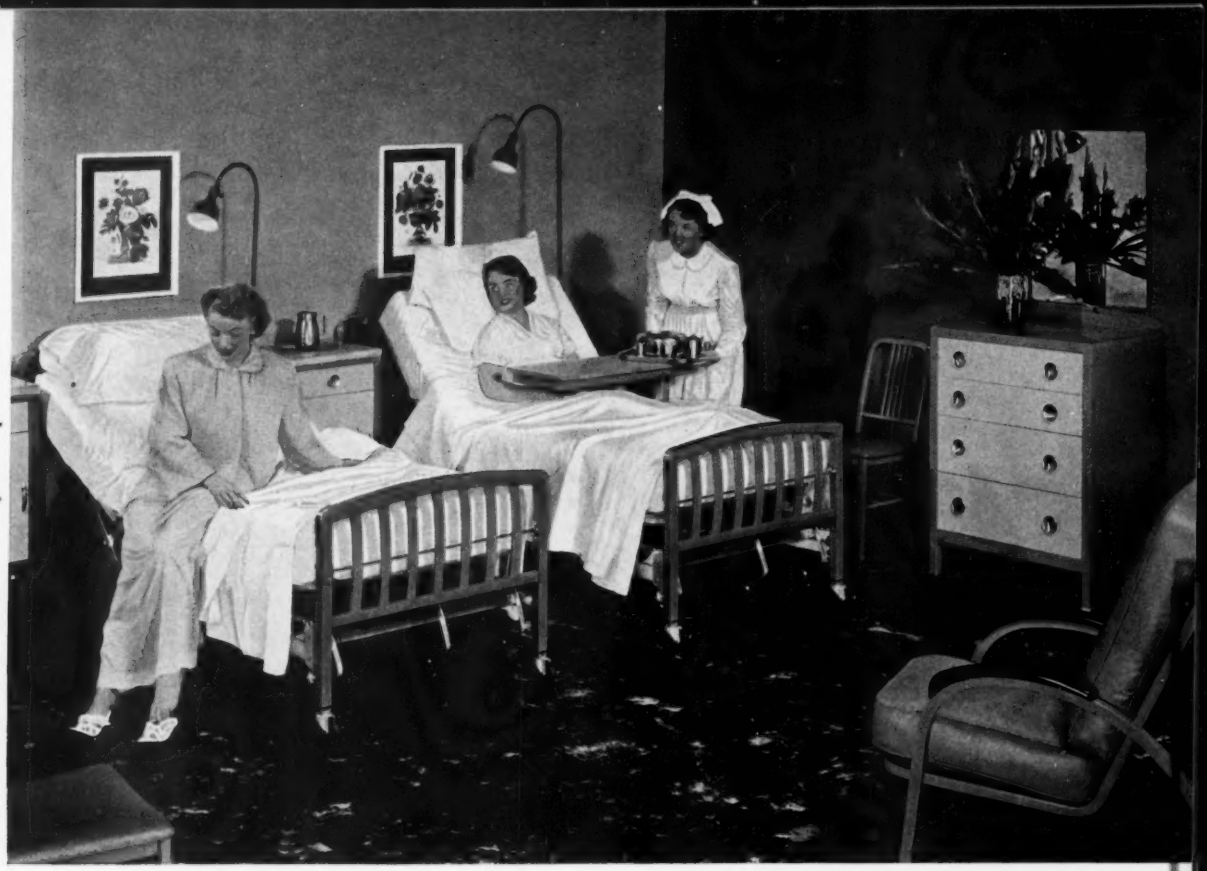
At St. John's Hospital, nearly 1000 Modine Convectors provide patients and staff with healthful, floor-to-ceiling heat. Architects: Maguolo & Quick, St. Louis. Engineer: Harry F. Wilson, St. Louis. General Contractor: McGough Bros., St. Paul, Minn. Heating Contractor: C. Wallace Plumbing Company, Inc., Dallas, Texas.

America's finest buildings use America's finest convectors

Choose from three enclosure types in Standard and heavy-duty Institutional models for free-standing, recessed or wall-hung installation

FOR today's hospitals, superior heating performance must be teamed with subtle styling and long-life construction. On all counts, Modine Convectors meet exacting professional standards. That's why more and more Modine Convectors are being specified by leading architects and engineers. For full information on heating at its finest, call your Modine representative. You'll find him listed in your classified phone book. Or write Modine Mfg. Co., 1549 DeKoven Ave., Racine, Wis.

Modine CONVECTORS



Magic Valley Memorial Hospital Selects Simmons Equipment for Service and Beauty

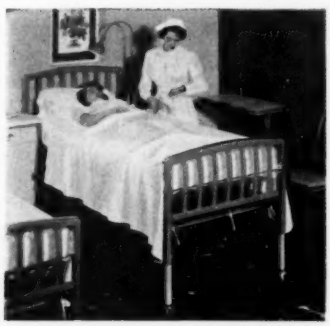
Only the best in modern hospital construction and equipment would satisfy the citizens of Twin Falls County, Idaho, when they erected their new hospital. That's why Simmons beds, furniture and Beautyrest mattresses are used in this new 160-bed hospital.

"From the ground floor grouping of all medical services, to the home-like atmosphere of the individual rooms, the Magic Valley Memorial Hospital is designed to a new concept of efficient, attractive service," says Mr. J. C. McGilvray, Hospital Administrator and President of the Idaho Hospital Association.

Shown above is one of the semi-private rooms planned by Mr. McGilvray and his staff. It is a symphony of soothing color, from its two-tone walls to the beautiful furniture finished harmoniously in dove green with grey.

Whether you are modernizing or planning new construction, call your Simmons hospital supply dealer, or, write us for helpful advice.

Illustrated above: *Room No. 80. Dove green with grey.* Magic Valley Memorial Hospital, Twin Falls, Idaho. This room is equipped with: H-880-3 Vari-Hite Beds with L-171 Deckert 3-crank Spring—F-440-F Bedside Cabinets—F-142-24 Chest with Mirror FM-42—F-732 Chairs—F-763 Arm Chair—F-885 Single Pedestal Overbed Table.



Simmons Vari-Hite bed ends are quickly adjustable from home bed height to hospital height by cranking. At the low height, patients enjoy a greater sense of security. In raised position, the patient is brought to the right height for nurse care.

Hospital Division **Simmons Company**

Write for new catalog of Simmons' complete line of hospital equipment.

Chicago 54, Merchandise Mart • New York 16, One Park Avenue • San Francisco 11, 295 Bay Street • Atlanta 1, 353 Jones Ave., N. W.

wire from Washington

PROCUREMENT

Within the federal government, a sort of super procurement board is at work attempting to line up all the supplies hospitals may need over the next few years, regardless of military and civil defense purchases.

Doing most of the planning is the Division of Civilian Health Requirements of Public Health Service, headed by Wesley Gilbertson. Legally, the division is responsible for presenting claims for all civilian health supplies—from aspirin to operating tables—to the agencies allocating available material.

The assignment sounds simple enough. Actually, it is incalculably complicated. On a month-to-month basis the division must see to it that scarce supplies are so distributed as to keep hospitals functioning at a high peak of service. At the same time, Mr. Gilbertson and his associates are expected to arrange matters somehow so that supplies will be on hand to meet all future calls.

Under normal conditions, the economic factors of supply and demand would answer all the problems, and Mr. Gilbertson, a sanitary engineer by profession, would be running something else for Public Health Service. But conditions aren't normal, and there is no prospect they will be normal for many, many years. A year and a half ago the division was created under the impact of the Korean war, Until the recent improvement in supplies, its job was to handle distribution almost on a hand-to-mouth basis.

Right now, there are relatively few really critical supply situations, so the division's experts are looking for trouble ahead—three, four and five years—and attempting to find solutions while there is time to spare. The facts are these: Supplies are adequate today in most lines only because military and civil defense procurement programs have not reached their maximum levels. When they are stepped up, there won't be enough available, unless production capacity also is stepped up sharply.

Mr. Gilbertson and his associates are attempting to convince certain manufacturers they should expand production to meet demands that will be evident three, four or five years from now. In May, the division started a comprehensive survey of all items used in the health fields. The objective is to determine present demand and supply and probable future demand and supply for specified years. By midsummer it is hoped the survey will be completed and the project reduced to a month-by-month check of the situation.

When it is determined that future demand for a certain item can be expected to outpace future anticipated supply, the division's experts set to work on the second phase of their project. They explain the situation to manufacturers, emphasizing that a greatly expanded market appears certain. Then, if this isn't enough to induce plant expansion, the division may appeal to Defense Production Administration on behalf of specific manufacturers, asking for tax amortization rulings for the new plants. On this the final decision is made by D.P.A.'s Office of Resources Expansion, and amortization benefits are granted only on a showing that the new production capacity is essential to national welfare.

Division of Civilian Health Requirements experts already are at work attempting to ensure more production of antibiotics, burn dressings, dental equipment, x-ray equipment and operating tables. In none of these items are current supply problems in the least critical, but purchasing schedules make it certain there will be critical shortages in the future unless supplies are increased.

In a few lines—particularly hospital beds and sterilizers—the division's troubleshooters have to contend with current serious shortages, as well as prospective shortages that could critically impede operations of hundreds of hospitals.

HOSPITAL CONSTRUCTION

Whatever problems may show up in the future, current hospital construction needs continue to be met fairly well. Copper supplies continue low, but in no other important category is demand running much ahead of supply. Announcement of fourth quarter allocations is expected shortly, and liberal quotas are hoped for because of an anticipated increase of about 25 per cent in Hill-Burton applications over the third quarter. Under a recent control order, nickel plated stainless steel or high nickel alloy may not be used in production, manufacture or assembly of an additional list of products, including operating tables, instrument stands, drying racks and counters. The expanded list now includes almost all hospital furniture. (For details, consult Schedule A Amendment to order M80.)

MENTAL HOSPITALS

Latest statistics from National Institute of Mental Health indicate that despite some building mental hospitals are still overcrowded—18.1 per cent over stated capacity. The institute cited a survey for the year 1949, which showed that nearly 700,000 persons were patients in 207 state mental hospitals. The report also emphasized the shortages of trained personnel in the mental health fields—physicians, clinical psychologists, psychiatric social workers, nurses, therapeutic workers, and, as usual, attendants. The ratio of physicians to patients resident in the hospitals was about one to 250.

A wide variation was shown among states. For example, New York had facilities to care for 5.6 mental patients per 1000 population, while New Mexico had facilities for 1.7 per 1000.

Free copies of the report may be obtained from National Institute of Mental Health, Bethesda 14, Md. Write for "Patients in State Mental Hospitals: 1949, Mental Health Statistics Current Report IMH-B52, No. 1."

GRANTS FOR DEFENSE AREAS

Unless—and it's unlikely—the surgeon general decides there is no need for the gifts, hospitals in defense impacted areas shortly will be able to apply for grants under the Com-

munity Facilities Act. Last year Congress enacted the legislation, but declined to appropriate any money for hospitals. Now $4,000,000 has been approved for various community facilities, including hospitals, with the surgeon general authorized to handle the allocation. At this writing, the Division of Hospital Facilities has not prepared application blanks, but they should be ready shortly, unless the surgeon general decides not to include hospitals. The tentative plan is to have state hospital agencies handle most of the administrative chores, including screening of applications.

Officials of the division caution again that hospitals will not be eligible for the grants unless certain conditions are met. The area must have been officially designated as a defense-impacted area, it must be established that the local community either cannot or will not supply the needed hospital services and application must first be made for help through the Hill-Burton program.

NO MONOPOLY

Physicians and others connected with doctor-sponsored prepaid medical plans may rest easier now, following the Supreme Court's decision in the Oregon State Medical Society case. The court did not pass judgment on alleged monopolistic activities of the society prior to 1941, but ruled that actions before that date could not be cited as evidence of the society's present or future conduct. Further, the court held that since 1941 (when the society switched from opposition to contract medicine to operating its own doctors' plan) there was no evidence the doctors were using illegal methods to compete with other plans. As an encouraging indication of the court's attitude toward doctor-sponsored plans, the decision stated: "The sale of medical services by doctor-sponsored organizations in the state of Oregon is not trade or commerce within the meaning of the Sherman antitrust laws. Nor is it commerce within the meaning of the constitutional grant of powers to Congress to 'regulate commerce among the several states.'" In another section, the court decided that physicians were in their rights in inquiring into practices and standards of any system which provided medical care.

NOTES

Public Health Service medical officers are blanketed in with all military personnel in the pay raise, which provides 4 per cent in base pay and 14 per cent in housing and subsistence allowances.

Indications are that the Senate will take no action on House-passed legislation reestablishing states' right to require retailers to observe state fair trade laws. After the Supreme Court nullified states' power last year, a series of price cutting movements started in a number of cities, particularly in drug items.

Dr. Paul Magnuson, chairman of the President's Commission on Health Needs of the Nation, is taking a two-month trip to England this summer for medical meetings, leaving Vice Chairman Chester I. Barnard in charge. During the summer the commission staff will be busy collating data assembled at the series of panel discussions conducted in the spring. Possibility is that some of the material may be released prior to completion of the commission's report at the end of the year.

Some leaders of the International Labor Organization, of which the United States is a member, are anxious to jack up national laws on treatment of working mothers through the technic of an international convention or treaty. One proposal is to make women on both industrial and nonindustrial jobs eligible for 12 weeks' maternity leave before and after confinement. Cash medical benefits would be "sufficient for the full and healthy maintenance of mother and child. . . ." If these provisions are written into an international treaty, and approved by our Senate, they would become effective in every state.

Atomic Energy Commission has brought the story of isotopes up to date with a new pamphlet, "Isotopes—A Five Year Summary of U.S. Distribution," available at Government Printing Office, Washington, D.C., for $1. It shows that 600 hospitals, and research laboratories in 46 states have received isotopes from A.E.C.

For the first time, the Federal Hospital Council (top national Hill-Burton agency) met with representatives of state hospital authorities. Recommendations made by the state people will be studied during the summer and acted upon at the council's next meeting, scheduled for October.

Half-way through the session, the House Ways and Means Committee (taxes and spending) was asked to approve a plan to encourage physicians and other self-employed persons to set up retirement funds. Money would be taxed by the federal government when it was paid back in pensions, not at the higher rate of the beneficiaries' top earning years. Sponsors asked that they be given only the same privilege that corporations have of postponing income tax payment on funds set aside for retirement.

Although Veterans Administration cut its staff by almost 3000 early this month, none of the layoffs came in professional staffs of hospitals. However, a few professionals not in hospitals, and nonprofessional hospital employes, were involved.

Final congressional action left only $75,000,000 in new funds for Hill-Burton grants during next fiscal year. This was the figure recommended by the budget bureau and approved by both House and Senate. Approval by the conference committee was automatic.

By the end of this month, Federal Civil Defense Administration will have spent or committed about $90,000,000 for medical supplies. States were slow to apply for matching grants, so most of the money from now on will be spent on all-federal regional stockpiles of medical supplies. About three-fourths of all C.D.A. money spent so far has gone for medical purposes.

National Bureau of Standards is enlarging its research and standardization program, making possible more work on spark hazards in hospitals. Safety factors will be evaluated, and conductive floorings, coatings and waxes will be tested. This work is described in "Summary Technical Report No. 1663," available at the bureau in Washington.

A new Wage Stabilization Board ruling requires that sick leave benefits in union contracts be submitted to Washington for individual approval. Formerly most were approved automatically under a different procedure.

If the special $100 monthly pay for military and P.H.S. doctors is retained after September 1, much of the credit should go to Sen. Lester Hunt (D.-Wyo.) himself a dentist. Senator Hunt separated this from the other more controversial issues of bonus and hazard pay for such duty as flying and submarine service.

LOOKING AROUND

New Art

A REFRESHING new technic in presiding at meetings was demonstrated at the concluding session of the Tri-State Hospital Assembly in Chicago last month by Sister Mary Ellen of Anderson, Ind., president of the Indiana Hospital Association, who may also have ushered in a promising new era in human relations. Introducing a talk by Graham Davis of the Commission on Financing Hospital Care, Sister Mary Ellen said, "Mr. Davis needs no introduction." Then she sat down, *without* introducing him —completing what may easily have been the most original contribution to the art of spoken communication since the discovery of the tongue.

All God's Creatures

A EUROPEAN architect who was here studying American hospitals was in our office the other day. Like so many foreign architects, doctors and administrators who visit here, he was overwhelmed by the size and technical perfection of our hospitals but troubled by what he said was our mechanistic approach to the care of the sick. "The human soul must be frightened and burdened by your vast, factory-like hospitals," he said.

We hear this sort of thing right along from European visitors. "Your hospitals are so huge that the individual patient is lost and becomes a case instead of a sick human being," they say. Or, "Your hospitals are often in the middle of your cities, with none of the surrounding gardens and trees that mean so much to sick people." Or, "There are so many machines in your hospitals that even nursing has become an assembly-line operation."

These are wrong reasons. Some of our hospitals are large, to be sure, but so are some hospitals—the best, in fact—in European cities. Many of our hospitals *are* surrounded by beautiful parks and lawns, while some hospitals in Paris and London and elsewhere abroad are in factory and tenement districts that match anything in Manhattan or Detroit or Chicago for urban ugliness. We do have more machines in our hospitals, perhaps, but only rarely do our machines enter into patient care; when they do, they are the same machines that are used for diagnosis and treatment elsewhere. Like our society, our machines are generally newer and shinier, but they are no more obtrusive.

Nevertheless, the visitors are right; there is a difference. This is something we have puzzled over many times, and we have come to the conclusion that it is actually a more profound thing than our visitors commonly suspect. The chief difference between American and European hospitals, we suggest, is a reflection of the difference between American and European cultures. In America we are a technology-happy, science worshipping society. We recognize an aristocracy of science; rightly or wrongly, we assume that doctors and nurses belong to it and patients do not. Thus in our hospitals there is a cleavage between staff and patients that has little to do with the age or size or location of the hospital, or the amount of machinery it contains. It is a cleavage between human hearts, akin to the separation of master and servant in older cultures.

The spirit that visitors from abroad miss in so many of our hospitals is a kind of coziness that can't easily be described. We sensed it once in the men's surgical ward of a hospital in England. It was teatime, and a group of patients and nurses was sitting around a table at one end of the ward, helping one another to tea and cakes and chatting sociably together. No such practice would be tolerated, of course, in our great teaching centers, where superb medical care is offered but must sometimes be thrust across a palpable gulf between staff and patient. These are the hospitals seen most frequently by visitors from

abroad. They might feel more at home in some of our less pretentious institutions—notably in those hospitals where doctors, patients and nurses are regarded alike as God's humble creatures.

See?

MOST patients don't know enough to distinguish between good and bad medical care, but they do know whether or not they like hospital food. This was the gist of a recent address to the American Dietetic Association by Harold Prather, administrator of the East Tennessee Baptist Hospital at Knoxville. Selective menus are not an extravagance but an economy, Prather argued. "A meal is the only pleasure of the hospital day," he reasoned. "If the food service is poor, the day is a disappointment. If it is properly cooked and attractively served, it plays a large part in creating a favorable attitude toward the hospital."

Out in Seattle, an 8 year old patient at Children's Orthopedic Hospital proved that Prather knows what he is talking about. As the boy was being discharged, *Washington Hospitals* reports, an intern asked him how he had liked his hospital stay. "It wasn't so bad, was it?" the intern suggested. The youngster agreed, but obviously without conviction. Then his face brightened.

"But you doctors sure cook good!" he said happily.

Notes on Aging

ONE DAY LAST WINTER, the *Nebraska Hospital Bulletin* reported, a visitor walked into the St. Elizabeth Hospital at Lincoln and asked for Sister Mary Mageline. Puzzled Sisters at the admitting desk sought aid from Sister M. Pacifica, St. Elizabeth's administrator. Sister Pacifica explained that Sister Mageline, who was the hospital's Superior when it was first established, had been dead for 20 years. The visitor then related that he was over 100 years old and could remember when the hospital site was farmland—back in the Eighties, that was.

But he hadn't come to the hospital just to inquire about Sister Mageline and talk over old times, the visitor said briskly. He'd heard that the hospital blood bank needed donations, and he was there to give some blood. "You're only as old as you feel," he told the astonished Sisters.

Convention

TURNING from serious business to hilarious entertainment and back again with the casual ease that is the special genius of the Southerner, some 1200 hospital people last month frowned and frolicked their way through the 22d annual Carolinas-Virginias hospital conference at Roanoke, Va. Old-timers who had been at the first conference remembered that attendance there was around 50—an indication of what has happened to hospitals in our time. Another sign-of-the-hospital-times was implicit in the observation of one administrator's wife as she looked around the teeming lobby of the Hotel Roanoke. "They could be big steel executives," she said, appraising the crowd of brisk, businesslike, prosperous looking administrators.

The oversize convention taxed the hotel the way disaster taxes a hospital. Extra beds were broken out of storage and set up in every available corner. Parlors and private dining rooms were turned into dormitories; in the best hospital tradition, the manager even had a bed rolled into his own private office. Friends doubled up in regular guest rooms, and strangers quickly became friends in shared accommodations.

Exhibits of hospital merchandise spilled out of the hotel's exhibition hall into the lobby, where the winning plans in a competition for architectural students were also on display. Attracting as much attention as any other exhibit in the place was one of the honorable mention plans: a round hospital, with patients' rooms around the outside, then a corridor ring, then a smaller ring of service facilities inside. Most of the visiting administrators who studied it could pick some flaws in the plan, but many agreed with the competition judges that it deserved applause for its free-swinging, creative originality—a rare quality that is sometimes troublesome but is nevertheless responsible for all the progress that has been made in architecture and hospital administration since the days of Aesculapius and his temple.

Not all the free-swinging originality at a hospital convention, as it turns out, is displayed by architects. At Roanoke, a couple of beer salesmen who happened to be in town looked in at the convention hotel to see what was going on. As sometimes happens, what was going on at the time was, or were, several cocktail parties at which suppliers attending the conference were entertaining their hospital friends. The salesmen mixed happily with the crowd and moved along from room to room, sampling hospital-type punch and, eventually, becoming noticeably euphoric.

Unable to identify the uninvited guests, one conscientious host finally suggested that they leave. When they protested that they liked it all right where they were, he called the house detective, who introduced stronger measures. As an exit was being accomplished under forced draft, one of the strangers, now thoroughly obstreperous, took a swing at the gendarme—a maneuver that promptly landed him across the street in the jug, proving that there are sensible limits even to famed Southern hospitality.

First Formula

HOSPITAL people who are struggling with county commissioners, welfare agencies and others to get reimbursable cost for care of indigents can point to a venerable and authoritative precedent—the earliest and unquestionably the simplest cost formula ever developed. It occurs in the familiar story of the Good Samaritan (Luke 10:30-37) who was moved by compassion to bind up the wounds of the man who had been stripped and beaten by robbers. The Samaritan then set the victim on his own beast, it is related, and brought him to an inn, and took care of him. "And on the morrow," the story concludes, "he took out two shillings, and gave them to the host, and said, Take care of him; and whatever thou spendest more, I, when I come back again, will repay thee."

We make

INCOME = OUTGO

with this new rate formula

FRED G. CARTER, M.D.
Superintendent
St. Luke's Hospital
Cleveland

THE system described here of establishing rates charged for services rendered to inpatients differs somewhat from any system heretofore employed. It relates charges directly to costs. It is fair and equitable to all classes of clientele, including Blue Cross, private insurance companies, other contracting agencies and self-pay patients. It ensures a 100 per cent return of expenses, provided billings are collected. It takes most of the guesswork out of rate making. It permits quick adjustment to higher or lower costs. Finally, it permits rapid adjustment to changing relationships with medical specialists.

The system is partially inclusive. It covers the cost of all services that might be used in common by all classes of patients, but excludes those services in which the costs cannot be equitably distributed to all patients. Extra charges are made for such services. Included in the extra charge category are anesthesia, blood and plasma, delivery room, extraordinary drugs, operating room, x-ray interpretations, miscellaneous, telephone, guest meals, and homegoing items. The costs of operating all these extra facilities are excluded from the calculations used in figuring the partially inclusive, inpatient daily service rates.

The costs of operating the various services which are included in the Daily Service Charge to inpatients for the first eight months of 1951 in our hospital are shown in Table 1, and the patient days accumulated during the same period are shown in Table 2.

Studies conducted by the Cleveland Hospital Council several years ago indicated that ward costs are 90 per cent of average per capita per diem cost; semiprivate costs are 100 per cent of average per capita per diem cost, and private room costs are 110 per cent of average per capita per diem cost. These cost ratios have been used for a number of years in determining rates to be paid to hospitals by Cleveland Blue Cross. They have also been used on a national scale to determine rates paid by governmental agencies to hospitals. We hold no brief for these cost ratios, however. Further studies may reveal the need for a different set of ratios. When, as and if they are developed they can be substituted readily for those used in this presentation.

Using this formula as a basis for rate making, we would derive our average per capita per diem cost of rendering the services covered by our daily service charge by dividing the total expense figure obtained in Table 1, namely, $1,453,818.81, by the total number of adjusted patient days for the same period shown in Table 2, namely, 86,201. Thus we would obtain an average per capita per diem cost of $16.86. Under this formula our ward cost would be 90 per cent of $16.86, or $15.75; our semiprivate cost would be 100 per cent of $16.86, or $16.86; our private room cost would be 110 per cent of $16.86, or $18.55. To prove the accuracy of these calculations, if we multiply the ward rate of $15.17 by the number of ward days, the semiprivate rate of $16.86 by the number of semiprivate days, and the private rate of $18.55 by the number of private room days, the sum of the products should equal the total expense of $1,453,818.81. This does not prove to be the case, however, as will be shown in succeeding paragraphs.

Where hospital statistics provide the number of days of patient care rendered to each category of patients, these, of course, would be the most nearly accurate figures to use. However, it is possible to get a fairly close estimate of the number of patient days in each category without such statistics. The "bed formula" can be used, which tells us how many beds we have in each category; these can be reduced to percentages, and the percentages may then be applied to

our actual number of adjusted patient days. (See Tables 3, 4 and 5.)

From the figures in these tables, it will be seen that the actual cost of rendering the services covered by the partially inclusive rate for the first eight months of 1951 was $1,453,818.81, but if we charged cost figured on the old formula basis and collected 100 per cent of billings, our income would be only $1,423,628.52, which represents a loss of $30,190.29 during the eight-month period. At this rate, our loss for a full year would be $45,285.44. Obviously, then, the validity of the old formula cannot be proved, and its use for rate-making purposes may result in financial losses to the hospital.

The difficulty with the old formula is found in the fact that it does not give proper weight to the various types of accommodations in arriving at per capita per diem cost figures. To accomplish this, however, the old 90—100—110 cost ratios must be retained, at least until more nearly accurate cost ratios are developed. A simple algebraic formula which will give proper weight to the different types of accommodations can then be utilized to develop a rate structure which will ensure a return of 100 per cent of costs —if 100 per cent of billings are collected. The procedure is as follows:

Let x equal average per capita per diem cost and semiprivate cost

.9 x equal ward cost

1.1 x equal private room cost

Using the patient days shown in Table 4, we then derive the following equation:

$$
\begin{aligned}
(39{,}739)\ .9x \text{ plus } 24{,}309x \text{ plus } (22{,}153)\ 1.1x &= \$1{,}453{,}818.81 \\
35{,}765x \text{ plus } 24{,}309x \text{ plus } 24{,}368x &= 1{,}453{,}818.81 \\
84{,}442x &= 1{,}453{,}818.81 \\
x &= \$17.22 \text{ average per capita per diem cost and semiprivate cost} \\
.9x &= 15.50 \text{ ward cost} \\
1.1x &= 18.94 \text{ private room cost}
\end{aligned}
$$

A comparison of per capita per diem costs derived from the old formula and the new formula is seen in Tables 6 and 7. The actual cost of rendering the services covered by the partially inclusive rate for the first eight months of 1951 was $1,453,818.81; if we charged cost for these services based on the new formula, our income would be approximately the same as our expense.

Following the results obtained by using the new formula to calculate per capita per diem costs for the various types of accommodations, we used these as the basis for a new, partially inclusive rate schedule at St. Luke's Hospital. The new formula costs are $15.50 for ward accommodations, $17.22 for semiprivate accommodations, and $18.94 for private room accommodations. On a bare cost basis, charges of $15.50 for ward, $17.25 for semiprivate and $19 for private would be justified when actual costs are rounded out to the nearest 25 cents in establishing the rates.

Inasmuch as it is impossible to operate a hospital on a bare cost basis, especially during these days of increasing inflation and constantly increasing costs, when calculations are obsolete almost before you can put them down on paper, it was decided that a 10 per cent "contingency markup" should be added to costs to assure continued solvency of the hospital. On a 10 per cent markup, the ward rate would be approximately $17, the semiprivate rate approximately $19, and the private rate approximately $21. In setting rates for private rooms, the addition of small differentials for the better rooms can be justified on the basis of larger size, better location and all-around greater desirability. Thus our rates for private rooms were set at $21, $22 and $23 for three types of private rooms. Hospitals without endowment income to cover free work might find it necessary to increase the contingency percentage markup above the 10 per cent figure used in this presentation.

It is widely understood that the first few days of a hospital stay are the costliest, because it is during these days that we render the most intensive care and do most of the analytical work on our patients. Accordingly, it becomes necessary to distribute the charges for the first eight days (average stay) of hospital care in a manner that will compensate for the expensive short stay. This principle is reflected in the sliding scale of charges suggested in Table 8.

It will be noted that surcharges of $4, $3, $2 and $1 are added to the basic charges during the first four days of hospital care, and that discounts of $1, $2, $3 and $4 are allowed for the fifth, sixth, seventh and eighth days of care, bringing the charges back to the basic rate if the patient remains in the hospital long enough to become an "average" patient from the length-of-stay standpoint. For each day that the patient remains in the hospital after the first eight days, he is then given a discount of $1 per day from the basic rate. Thus all patients, except the short stay cases, will pay per capita per diem cost (plus the "contingency" percentage) and the latter will be asked to pay proportionately higher rates per day because of the greater costliness of the services rendered during the short stay. Any seeming profit from the surcharge accumulated during the first four days finally is dissipated through the $1 discount that is allowed after the first eight days.

On the basis of actual costs for the first eight months of 1951, it was found that the portion of cost of the special services (such as laboratory, basal metabolism, electrocardiography, electroencephalography, blood and plasma administration expense exclusive of blood and plasma, physical medicine, oxygen therapy, and pharmacy) now included in the inpatient daily service charge was approximately 10 per cent of the total inpatient cost for rendering all inpatient services. (See Table 9.)

INSURANCE COMPANIES INTERESTED

The cost of these special services is of particular interest to private hospitalization insurance companies, and it would appear proper for these companies to allocate 90 per cent of the total hospital bill for room, board, nursing care, and general administrative expense, and 10 per cent for special services included in the inpatient daily service charge. This cost and allocation information was supplied to the insurance companies with which we do business.

According to the schedule of charges in Table 8 for inpatient service, the charge to the semiprivate patient remaining in the hospital eight days would be $152, of which 90 per cent, or $136.80, would be allocated to board, room, nursing care, and general administrative expense, and 10 per cent, or $15.20, would be allowed to special services included in the daily service charge. This percentage charge for special services applies to

all patients, regardless of whether or not they use all the services included. It is a "ready-to-serve" charge to cover any or all the services that may be needed. As our costs change from time to time, these percentages will change. Since the expense of these services is now covered in the inpatient daily charge, we have decreased significantly the handling of charges in the business office.

The insurance companies were informed that the aforementioned services formerly regarded as "extras" will not appear in detail on our billings. All this means that a policyholder of an insurance company which pays a fixed indemnity rate plus extras may find that the part of his bill for which he is personally responsible will be somewhat larger under this new rate schedule, because of the inclusion of certain extras in the new daily service charge, unless the insurance companies adjust their benefits in some way to the changed situation here. We do include in our billings to the insurance companies, however, the breakdown of extra charges listed in our schedule of rates for inpatient services, such as x-ray, anesthesia, operating room, delivery room.

TYPES OF SERVICES COVERED

The inpatient daily service charge covers all services except anesthesia, x-ray interpretation, operating room, newborn daily charge, delivery room, extraordinary drugs, miscellaneous charges, and blood and plasma. Extra charges to the inpatient are levied for all these services and supplies because it is felt that the cost of these facilities cannot be distributed equitably and fairly to all the patients.

Certain features regarding the setting of these extra charges should be noted. The technical expense of operating the anesthesia department, for example, has been allocated to the various procedures performed in the operating room and the delivery room and becomes part of the expense used in calculating the charges for these services. With the technical expense of operating the anesthesia department removed, the extra charge to the inpatient for anesthesia then becomes simply the professional anesthesiologist's fee. The hospital reserves the privilege of final approval of the fee schedule for his professional service.

The technical expense of operating the x-ray department was included in

TABLE 1: Costs of Operating Various Services

1. Administration	$ 179,948.64
2. Dietary	196,450.07
3. House and property	276,036.99
4. Professional services	
Medical and surgical	57,600.67
Nursing service	304,553.73
Nursing education	85,550.51
Radiology (technical)	30,915.73
Laboratory	59,795.49
Basal metabolism	501.85
Cardiology	6,551.09
Encephalography	1,176.36
Transfusion service (exclusive of blood and plasma)	10,406.30
Physical medicine	4,563.77
Oxygen therapy	5,716.28
Pharmacy	57,370.21
Central supply	73,647.22
Medical records	21,878.86
Social service	1,673.60
Depreciation	79,481.44
	$1,453,818.81

TABLE 2: Patient Days
(First Eight Months 1951)

Adult patient days	82,720
Infant days	13,922
Infant days divided by 4	3,481
Adjusted patient days (Adult plus ¼ infant days)	86,201

TABLE 3: Bed Formula

	No. Beds	% of Total
Ward beds	183	46.1
Semiprivate beds	112	28.2
Private beds	102	25.7
	397	100.0

TABLE 4: Patient Days

Ward	46.1% of 86,201	39,739 patient days
Semiprivate	28.2% of 86,201	24,309 patient days
Private	25.7% of 86,201	22,153 patient days

TABLE 5: Financial Result
(Old Formula)

Ward	39,739 days x $15.17	$ 602,840.63
Semiprivate	24,309 days x 16.86	409,849.74
Private	22,153 days x 18.55	410,938.15
		$1,423,628.52

TABLE 6: Daily Costs

	Old Formula	New Formula	New Formula Increase
Ward	$15.17	$15.50	$ 0.33
Semiprivate	16.86	17.22	0.36
Private	18.55	18.94	0.39

TABLE 7: Financial Result
(New Formula)

Ward	39,739 days x $15.50*	615,954.50
Semiprivate	24,309 days x 17.22	418,600.98
Private	22,153 days x 18.94	419,577.82
		$1,454,133.30*

*The discrepancy of $314.49 between the expense figure of $1,453,818.81 and the income figure of $1,454,133.30 is explained by the dropping of decimals.

TABLE 8: Schedule of Charges
(10 per Cent Markup)

Basic Charge	17	19	21	22	23
			Private		
Days of Service	Ward	Semi-Private	A	B	C
1	$ 21	$ 23	$ 25	$ 26	$ 27
2	41	45	49	51	53
3	60	66	72	75	78
4	78	86	94	98	102
5	94	104	114	119	124
6	109	121	133	139	145
7	123	137	151	158	165
8	136	152	168	176	184
Day Rate After 8th Day	16	18	20	21	22

TABLE 9: Total Inpatient Costs First Eight Months

	Cost—First 8 Months of 1951	% of Total
Inpatient cost included in inpatient daily service charge:	$1,311,169.32	90.19
Cost of special services included in inpatient daily service charge (Lab., BMR, EKG, EEG, Blood and Plasma Adm. (exclusive of blood and plasma), Phys. Med. O. Therapy, Pharm.)	142,649.49	9.81
Total	$1,453,818.81	100.00

the inpatient daily service charge as of April 1952. With this expense removed from our former x-ray charges, the extra charge for x-ray to the inpatient then becomes the professional radiologist's fee. The hospital also reserves the privilege of final approval of this fee schedule. More will be said later about x-ray fees.

ESTIMATING EXTRA CHARGES

The extra charge to the inpatient for each type of operation performed in the operating room is calculated by a formula similar to the one used in developing accommodation costs, considering the distribution by number, of the various types of operations performed during the first eight months of 1951 and weighting the costs of the various procedures in accordance with the following schedule:

x equals basic cost of major operation,
1.5x equals basic cost of double major operation,
.5x equals basic cost of minor operation,
.75x equals basic cost of double minor operation,
.25x equals basic cost of very minor operation.

Using the total direct operating room cost as a base, the cost of each procedure may then be computed. The same formula is used for computing the cost of technical anesthesia for each procedure. The operating room cost, plus the technical anesthesia cost, plus 10 per cent, is the operating room charge.

The extra charge to the maternity patient for any type of delivery performed is calculated as follows: The total direct cost of operation of the delivery suite, divided by the number of deliveries, provides a basic delivery room cost per delivery without anesthesia. The technical anesthesia cost for a major operation as calculated in computing the operating room charge is added to this basic cost to provide a basic cost per delivery, including anesthesia. The 10 per cent contingency factor is added to this total to provide the charge to the patient.

Since the cost of caring for newborn infants has been determined to be one-fourth of the cost of caring for adult patients, the newborn daily service charge is calculated as follows: Average ward inpatient basic daily cost, divided by four, equals average newborn basic daily cost (costs common to all patients). The direct cost of operating the nurseries divided by the total number of newborn days equals average direct cost of nurseries per newborn day. The average newborn basic daily cost, plus the average

direct nursery cost per newborn day, equals the total newborn basic daily cost. The contingency factor of 10 per cent is again added to the total newborn basic daily cost to provide the charge.

A charge of cost plus 10 per cent is levied for very expensive drugs and medications not included in the hospital formulary. Miscellaneous charges are based as closely as possible on cost plus 10 per cent. The technical or administrative expense of blood and plasma is included in the inpatient daily service charge, therefore the former service charge has been dropped and extra charges to the inpatient are made only for the blood and plasma used.

The partially inclusive rates as calculated here on an eight-month cost experience were made effective Dec. 1, 1951. It was found shortly after the new rates were put into effect that they were obsolete because of the fact that the eight-month period did not reflect sufficiently our current costs. The rates were recalculated and revised on Feb. 1, 1952, on the basis of a current quarter cost experience. We feel that the cost experience of the current quarter is the period which we will use both in calculating rates in the future and in comparing current rates to current costs.

USED FOR ADJUSTING RATES

The accompanying control report (Table 10) has been incorporated in our monthly financial statement for use in adjusting the rates in effect to current cost. From the experience for the quarter ending Feb. 29, 1952, it will be noted that it would be possible for us to lower our rates 50 cents per day for ward and private rooms and 25 cents per day for semiprivate. Instead of lowering our rates, however, as of April 1, 1952, we added the technical costs of x-ray to our regular service. We did this without increasing our rates, since it amounts to 40 cents per patient per day. When this was done, the extra charge to the inpatient for x-ray service was reduced on the average about 65 per cent. You will note also that our current costs plus 10 per cent figure in the control report (Table 10) is rounded off to the nearest 25 cents as this is the procedure used in rounding off in the rate calculation.

Inasmuch as we get all our costs out of our daily service rate, it is no longer necessary for us to make a

TABLE 10: Inpatient Monthly Rate Control Report
Costs of Services Included in Daily Service Rate February 1952

		Month of February 1952	Quarter Ending February 29, 1952	% of Total Cost
GROUP I:	Meals, Room, Regular Nursing Care, and General Administration Expense	$171,423.08	$534,659.08	90.33
GROUP II:	Special Services Included in Daily Rate (Lab., BMR, EKG.) Service for Giving Blood and Plasma (Not Including Charge for Blood and Plasma), Physical Medicine, O., Drugs.	16,589.43	57,267.72	*9.67
TOTALS		188,012.51	591,926.80	100.00

*These services in Group II consistently average 10%

	Costs for Quarter Ending February 29, 1952, by Type of Bed Accommodation			Basic Rates Based on Cost Plus 10% Rounded Out to Nearest 25 Cent			Amount That Rate Is Over or Under Cost Plus 10%**	
	Patient Days in Quarter	Per Capita per Diem Cost	Total Cost in Quarter	Quarter	Month of February 1952	Av. Rates in Effect February 1952	Quarter Ending February 1952	Month of February 1952
Ward	14407	$17.35	$249,961.45	$19.00	$18.50	$19.50	+0.50	+1.00
Semiprivate	8818	19.28	170,011.04	21.25	20.50	21.50	+0.25	+1.00
Private	8109	21.21	171,991.89	23.25	22.50	23.75	+0.25	+1.25
TOTALS	31334		591,964.38					

**Rates vs. costs for February 1952 are signaling a decrease in rates of $1 per day for wards and semiprivate rooms and $1.25 on private room. Rates for the quarter ending February 29, 1952, are signaling a rate reduction of $0.50 on wards, $0.25 on semiprivate, and $0.50 on private room.

profit on special services to make up the deficits in other departments. This appears to be a much fairer distribution of costs than the method which we used previously, which consisted of loading the charges for special services to make up for losses in other departments. It also enables us to settle our differences with the x-ray men in regard to their economic relationships with the hospital. We merely lower the charges for x-ray service and let the x-ray men take all the income, after deductions for bad debts.

This control report also indicates that it is possible to determine in a matter of seconds whether our rates should be increased or lowered, and how much. We had thought of setting cost plus 15 per cent as a signal for lowering the rates, and cost plus 5 per cent as a signal for increasing them. Either change would bring the rates back to cost plus 10 per cent, but we are not anxious to change the rates oftener than once in three to six months.

It is our hope that out of all this work and experimentation, we may be able to derive a more or less standard method for setting rates for hospitals. We hope particularly to make some contribution to the third party payment question which has been under consideration for several years in the hospital field.

President's Commission in Action

PAUL B. MAGNUSON, M.D.
Chairman
President's Commission on the Health Needs of the Nation
Washington, D.C.

LAST November, without a word of warning I got a call from the White House that the President of the United States wanted to see me. I took the train from Chicago that night, and the next morning met with the President. The President laid the cards right on the table. He said he was deeply concerned with the health of the American people in these trying days of all-out mobilization. He said he had made certain proposals to bring more and better medical care to the people, but these proposals had precipitated an emotional argument which had clouded the issue. The President said he was not necessarily committed to any one plan; if any group could come up with a better series of proposals than the ones he advocated, he would be the first to support them if they would ensure better health for all the people.

For that reason, he said, he had decided after long deliberation to set up a Presidential commission to get at the facts. He offered me the chairmanship, and promised me an absolutely free hand in choosing the members of the commission.

For the record, I want to say that I had absolutely no interference or pressure in selecting this commission. All the members were suggested by me to the President after I considered their interests, ability and fairmindedness. No one in the White House ever raised a question as to whether an appointee was a Democrat or a Republican, or whether he was in favor of the President's plan or not.

Condensed from an address to the Medical and Chirurgical Faculty, State of Maryland, April 1952.

Maybe I'm prejudiced, but I think this is the best of a long line of Presidential commissions. It is absolutely free of politics; we have laid down a rule that no one from a government agency shall be in any policy-making job.

The commission has one major objective. The Presidential directive reads: "During this crucial period in our country's history, it will make a critical study of our total health requirements, both immediate and long-term, and will recommend courses of action to meet these needs. The commission is authorized and directed to inquire into and study the following:

"(a) The current and prospective supply of physicians, dentists, nurses, hospital administrators and allied professional workers; the adequacy of this supply in terms of the present demands for service, and the ability of educational institutions and other training facilities to provide such additional trained persons as may be required to meet prospective requirements.

"(b) The present ability of local public health units to meet demands imposed by civil defense requirements and by the needs of the general public during this mobilization period.

"(c) The problems created by the shift of thousands of workers to defense production areas requiring the relocation of doctors and other professional personnel and the establishment of additional facilities to meet health needs.

"(d) The degree to which existing and planned medical facilities, such as hospitals and clinics, meet present and prospective needs for such facilities.

"(e) Current research activities in the field of health and the programs needed to keep pace with new developments.

"(f) The effect upon the continued maintenance of a desirable standard of civilian health of the actions taken to meet the long-range requirements of military, civil defense, veterans' and other public service programs for medical personnel and facilities.

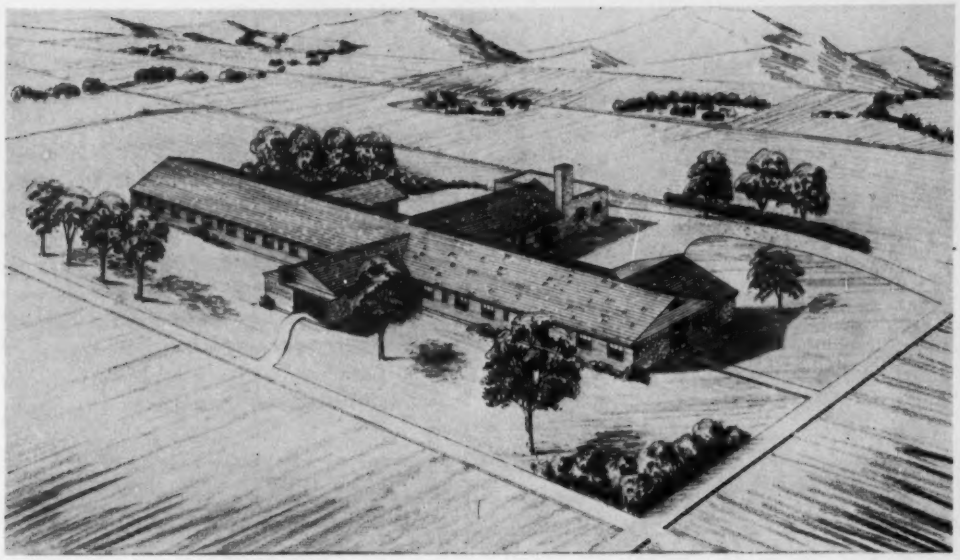
"(g) The adequacy of private and public programs designed to provide methods of financing medical care.

"(h) The extent of federal, state and local government services in the health field, and the desirable level of expenditures for such purposes, taking into consideration other financial obligations of government and the expenditures for health purposes from private sources."

The commission has divided its work up into three parts:

1. Assessing the total health resources for the country. A staff of technicians has been working on this since the middle of January, digging into the complexities of number of health personnel, hospital beds, health education facilities, health insurance coverage, costs of medical care, and so on. Some time in the fall, the commission hopes to bring out an important volume entitled: "The Health Resources of the American People." We think it will be the first completely factual analysis of our total health strengths and shortcomings.

(*Continued on Page* 138)



WAR MEMORIAL HOSPITAL, POWELL, WYO.

THE MODERN HOSPITAL OF THE MONTH

Serving a New Community

JAN V. T. WILKING
Goodrich and Wilking
Associated Architects
Casper, Wyo.

THE War Memorial Hospital at Powell, Wyo., is located in a rural community of approximately 10,000 people, concentrated on about 152,000 acres. The city of Powell itself has a population of 3800. The population is made up of a large proportion of young families who are moving to the community to homestead the newly developed land. The community is well abreast of the times, which is evidenced not only by the new hospital, but also by a complete school system made up of six modern school buildings.

The hospital has a capacity to serve the surrounding community within the especially created Hospital District No. 1 of Park County, Wyoming, which includes the New Reclamation Project farms opened at Heart Mountain. The district also includes several oil fields. However, the oil drilling activity of the community has been fortunate in having had but few accidents to date.

The total cost of the project, including equipment, will be approximately $330,000. The Public Health Service will furnish 33 1/3 per cent and the balance will be made up of a $200,000 bond issue and public contributions.

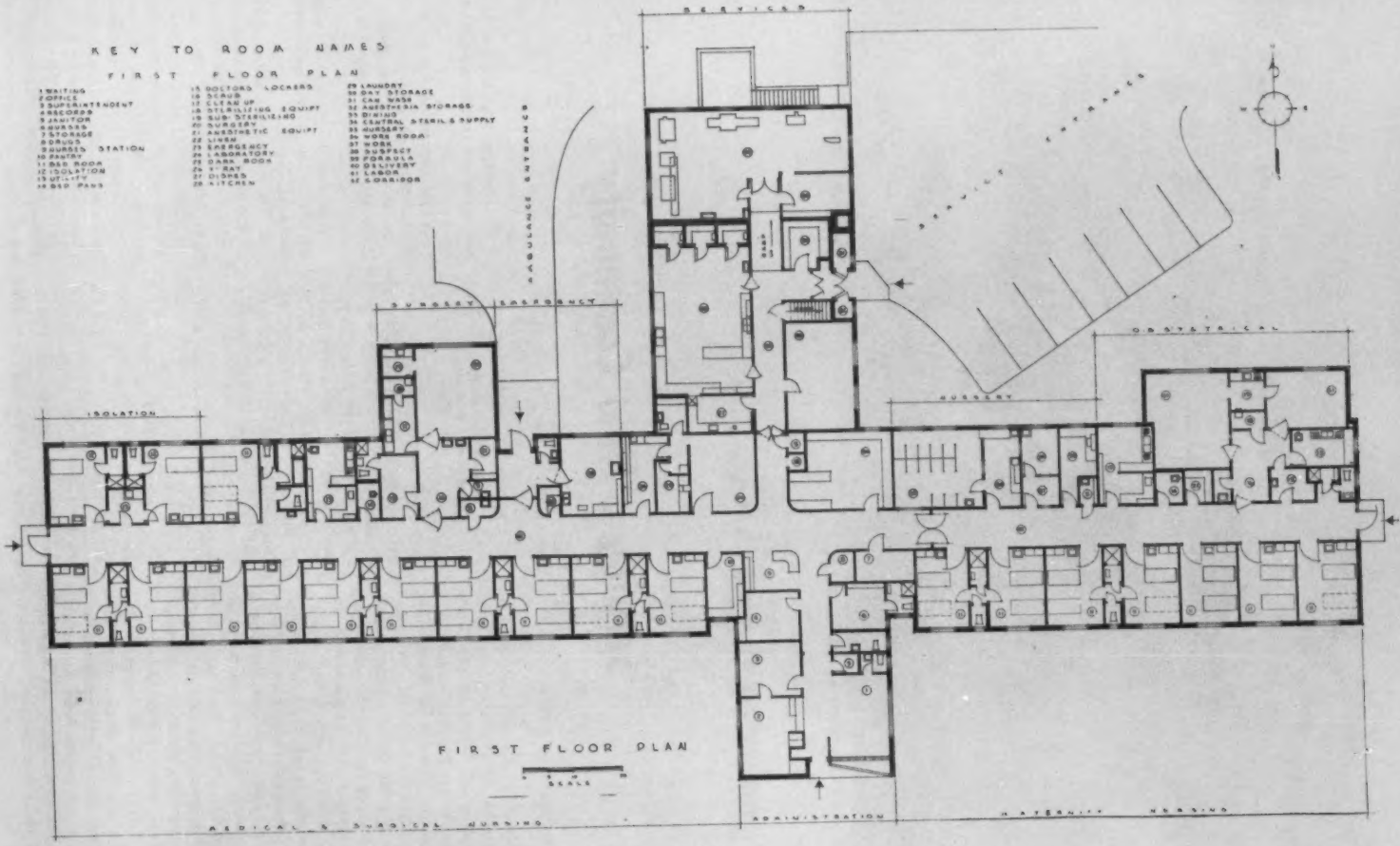
COSTS

Cost per Bed	$8,918.91
Cost per Square Foot	$16.99
Cost per Cubic Foot	$1.35
Total Square Foot Area	19,422
Square Foot Area per Bed	498

The site, approximately 548 by 210 feet, is on the northwest edge of the city.

Design features of interest include the following:

1. All patients' rooms, except isolation and one spare room, face the south.
2. Service and emergency entrances are at the rear and have separate driveways.
3. The obstetrical wing, which is to the east of the administration wing, can be closed off and still permit the viewing of new babies in the nursery.
4. The medical and surgical section, including operating room, emergency room, utility rooms, and so on, is in a separate wing to the west of the administration wing and can be expanded as conditions warrant.
5. All service department facilities, including a fully equipped kitchen, dining room, and complete laundry,


KEY TO ROOM NAMES
FIRST FLOOR PLAN
1 WAITING
2 OFFICE
3 SUPERINTENDENT
4 RECORDS
5 JANITOR
6 NURSES
7 STORAGE
8 DRUGS
9 NURSES STATION
10 PANTRY
11 BED ROOM
12 ISOLATION
13 UTILITY
14 BED PANS
15 DOCTORS LOCKERS
16 SCRUB
17 CLEAN UP
18 STERILIZING EQUIPT
19 SUB STERILIZER
20 SURGERY
21 ANAESTHETIC EQUIPT
22 LINEN
23 EMERGENCY
24 LABORATORY
25 DARK ROOM
26 X-RAY
27 DISHES
28 KITCHEN
29 LAUNDRY
30 DAY STORAGE
31 CAR WASH
32 ANESTHESIA STORAGE
33 DINING
34 CENTRAL STERIL & SUPPLY
35 NURSERY
36 WORK ROOM
37 WORK
38 SUSPECT
39 FORMULA
40 DELIVERY
41 LABOR
42 CORRIDOR
SERVICED
EXPANSION
SURGERY
ISOLATION
OBSTETRICAL
FIRST FLOOR PLAN
SCALE
MEDICAL & SURGICAL NURSING
ADMINISTRATION
MATERNITY NURSING

WAR MEMORIAL HOSPITAL
POWELL, WYO.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

are in the central wing on the rear of the building.

6. The boiler room is located under the laundry and ample storage space is provided in the basement.

7. General construction details are as follows: Concrete footings and foundations; concrete floor slabs; steel studs, with exterior walls insulated and covered with brick veneer.

Walls are smooth plaster with flat wall and enamel paint. Floor covering is asphalt tile.

A gable roof is provided so that all steam, water, gas and oxygen lines are accessible. All air-conditioning units are located in the attic and are easily accessible.

8. Mechanical equipment includes two low-pressure boilers (one a stand-by) and one high-pressure boiler. Fuel for all heating and cooking will be natural gas. Radiant panels in ceilings are supplied by hot water through heat exchangers from the low-pressure boilers. Automatic room and zone temperature controls are provided.

A complete water softening system is provided.

A stand-by emergency electric power system, fully automatic, is provided in case of power failure.

Oxygen is piped to all patients' rooms, operating rooms, delivery room, and nursery from a central oxygen manifold in the basement.

A complete nurses' call system is provided.

9. The building will be completely equipped with furniture, laundry equipment, bedpan washers and sterilizers, autoclaves, instrument cabinets, bassinets, x-ray equipment, operating tables and lights.

United They Build

Terre Haute's two hospitals prove the value of cooperative enterprise

CITIZENS of Terre Haute, Ind., stopped everything March 11 to mark a significant milestone in their quest for more nearly adequate hospital facilities. Ground was formally broken for $2,000,000 worth of expansion at its two general hospitals—Union and St. Anthony.

With Surgeon-General Leonard A. Scheele of the U.S. Public Health Service, Indiana Governor Henry F. Schricker, and other national and state officials as honor guests, Terre Haute did figuratively what it had been doing literally for more than three years—spade work.

It all started back in 1948 when, encouraged by the possibility of help through the Hill-Burton hospital construction program and spurred by some local agitation for a third, public, hospital, civic leaders began thinking about raising funds to expand and remodel St. Anthony and Union hospitals which have been serving their community for more than 60 and 50 years respectively.

The building fund of each hospital was far short of the necessary capital, even with Hill-Burton help, to make so much as a start on work necessary to bring the hospitals near to meeting the needs as shown by the Indiana survey of hospital facilities. For more than a year both hospitals contemplated capital campaigns. At the same time, however, citizens concerned with the over-all needs of the community were giving serious consideration to a more cooperative approach to its hospital problem.

Result of this concern and planning was the organization late in 1949 of the United Hospital Project to raise local funds on behalf of the building needs of both Terre Haute hospitals.

It was a home-grown effort, no professional fund raising. There is a considerable body of opinion in Terre Haute now which thinks the job could have been done more expeditiously with professional fund raising counsel, but the community takes a certain pride in the fact that a city, never particularly hospital conscious, scraped together enough local money, largely through the United Hospital Project, to become eligible for $987,000 of Hill-Burton matching funds. Construction under contract will give Terre Haute 120 additional beds, new surgery and other service facilities in both hospitals.

The United Hospital Project became more than a fund raising organization. Under the farsighted leadership of its co-chairmen, Leonard B. Marshall, president of the board of Union Hospital, and Anton Hulman Jr., chairman of the advisory board of St. Anthony Hospital, the Terre Haute institutions began to work and plan together as they never had before. The people of the Terre Haute area have come to think of its *community* hospital facilities, not in terms of hospitals as individual entities.

The United Hospital Project ground breaking celebration was a citizen-centered affair with a generous representation of state and national health and public officials who have had a part in the program at various levels. Activities of the day were coordinated by a special committee of the Terre Haute Chamber of Commerce.

Starting at noon with a community luncheon sponsored by Rotary and Exchange (Tuesday's their day in Terre Haute) the program continued with clock-like precision to Union Hospital at 2 p.m. and St. Anthony at 3 p.m.

St. Anthony Hospital operated by the Poor Sisters of Saint Francis was organized in 1882. Union Hospital, a voluntary nonprofit institution, was organized as the Terre Haute Sanitarium in 1892. There has been no major hospital expansion in Terre Haute for 30 years.—FRANK BRIGGS, *administrator, Union Hospital, Terre Haute, Ind.*

Use the new reporting forms to obtain

Prompt Payment for Polio Care

HART E. VAN RIPER, M.D.
Medical Director
National Foundation for
Infantile Paralysis
New York City

THE National Foundation for Infantile Paralysis, through the introduction of newly revised patient care reporting forms early in July, expects to make available comprehensive clinical and financial data on the care of poliomyelitis patients. One important benefit to hospitals from the use of these forms should be prompter payment of bills.

The use of authorization forms was instituted by the national foundation in 1948, following the first of several heavy epidemics. They were generally well accepted because they served to correct a number of serious problems of concern both to hospitals and to national foundation chapters.

RETROACTIVE PAYMENTS DEMANDED

Prior to the introduction of these forms, hospitals had often sent bills to families of polio patients who in turn simply rerouted them to chapters for payment with no personal interview or agreement to render assistance. In other instances, hospitals had billed National Foundation for Infantile Paralysis chapters directly. Frequently chapters had no knowledge that the patients were in the hospital, and had not been requested to provide financial assistance. Often bills were submitted to chapters only after they had mounted to several thousand dollars, and retroactive payments were demanded.

The forms in use until now have corrected many of these problems but a number still exist. It is hoped that the new forms will solve many of these problems and provide a great deal of valuable information not heretofore available. The rising incidence of poliomyelitis in the United States during the last four years makes it increasingly important to solve the problems of reimbursement for patient care, and to obtain more information on the needs for care.

Chapters, unadvised of admissions to a hospital, or of the recruitment of nurses whose salaries they are expected to underwrite, can neither anticipate what their expenses will be nor properly budget their funds to meet obligations. Chapters with insufficient funds to cover expenses can request special aid funds from national headquarters, but often much time has been lost because they were unaware of mounting obligations. This situation frequently resulted in unduly long delays in the payment of hospital bills.

In 1949 one of the western states experienced a high incidence of poliomyelitis. Nurses were recruited by one hospital to care for its many patients and, without notification to the chapter, nursing bills accrued in the neighborhood of $30,000. When ultimately billed for this, the chapter properly refused to reimburse the hospital because the recruitment of nurses had not been authorized. Nor was the local county chapter inclined to underwrite all of these special nursing charges since many patients came from other counties in the state. In 1950, the bills were finally paid after much discussion and going back over records to see where responsibility could be placed. This situation could have been avoided had the hospital notified chapters on admission of patients requiring additional nursing service, and requested certification for payment of bills from responsible chapters.

In another western town, bills for polio patients piled up from 1950 until the spring of 1951. The hospital was small, had no surplus funds, and carrying bills for such a long period created many problems. Chapters complained that the hospital kept patients too long—two cases in April 1951 had been in the hospital from August 1949, with chapters automatically paying bills without formal certification. The hospital was billing patients and chapters at different rates. (This circumstance was due to a complicated bookkeeping system and was not intentional on the part of the hospital.) One chapter complained that the first indication it had that a patient had been transferred from one hospital to another (where rates were much lower) was when it began to receive hospital bills. Bills were finally paid but the hospital had to wait for an extended period of time at great inconvenience. Proper use of certification forms would have prevented this trouble.

REFUSED TO USE FORMS

Another hospital in a midwestern city refused to use National Foundation for Infantile Paralysis forms. This hospital filed a reimbursable cost of $15.47 per day, but national foundation chapters were billed excessively at a ward rate of $9.25 plus extras, well above the reimbursable cost. Chapters had to refer many bills to national headquarters for verification of questionable charges. When the hospital finally agreed to use forms, disagreements were settled prior to the accumulation of large debts.

For the past few years more than two-thirds of the net funds raised each year by the National Foundation for Infantile Paralysis through the March of Dimes has been spent on the patient care program, which corresponds in many ways to other programs administered by third parties, *e.g.* Blue Cross. The foundation's program is unique in that it is administered largely by chapter volunteers. Similar to others in many ways, the national foundation program is geared basically to assist patients in obtaining high quality care at or near actual cost.

Proper administration of public voluntary funds requires administrative methods and devices which will assure achievement of program objec-

tives with a minimum of red tape. The National Foundation for Infantile Paralysis is especially concerned to see that its publicly subscribed funds are used for the greatest possible benefit. It must, therefore, review systematically and analyze carefully its program of assistance in terms of quality and cost.

For at least two years the National Foundation for Infantile Paralysis has been employing two basic concepts of medical care administration in its program: (1) certification in advance for payment for the care of a particular individual for a specific length of time, and (2) prior agreement with the vendor of services on the amount of charges (per diem rate, fixed outpatient charges, and so on). These two concepts of administration must be based upon certain informative data, to be obtained only through the use of certification forms. The newly devised reporting forms will provide the national foundation with much more factual information upon which to build its various assistance programs and to conduct more efficient administration of them.

Tabulation of the information contained on these forms will provide data on a national basis on many aspects of poliomyelitis, such as:

1. The distribution of poliomyelitis cases according to age, sex and color.
2. The location of patients by state, county and hospital, and the type of service, size and control of hospital.
3. The extent of paralysis and dependency upon respiratory aids, use of orthopedic appliances, length of stay in hospital, specialty of attending physicians.
4. The cost of poliomyelitis patient care—inpatient and outpatient hospital cost, nursing and physical therapy cost, physician's charges.
5. The proportion of cost paid by National Foundation for Infantile Paralysis, Blue Cross, polio insurance companies, the patient or his family.

With more information available, reasonably accurate estimates could be made of expected expenses (both locally and nationally) based upon expected incidence. Through the new system of reporting, it would be possible for the National Foundation for Infantile Paralysis to spot epidemic situations, so that special professional consultation and epidemic aid can assist more effectively in meeting the problems of local hospitals and health authorities. More specific information will be available for working with various professional groups at the national, state and local levels to plan and establish better acute care and after-care programs. For example, with information available on the number, condition and location of patients with respiratory difficulty, plans might be developed for the establishment of centers in areas of need where respirator patients might be grouped for more nearly adequate care. Information revealed regarding the use of orthopedic appliances might indicate a need for more or better bracemaking services. If an area shows a longer than average period of hospitalization for patients, investigation might reveal inadequacies of outpatient facilities and plans could be formulated for establishing a follow-up program.

No statistical reporting system will solve all of these problems, but the availability of comprehensive data will provide the National Foundation for Infantile Paralysis with a sounder basis for planning its program of assistance to poliomyelitis patients.

A special effort has been made to incorporate all practical, labor saving features into the revised forms. Three new patient care forms replace the six forms previously used to report ad-

NEW POLIO PAYMENT FORMS

The five forms cover admission of patients, continued care, discharge or death, statement of patient care service, and statement of hospital care rendered by emergency personnel.

missions, continued care and discharge of poliomyelitis patients. Each form contains several copies of different colors, interleaved with the one-time use carbon paper. On completion, the copies of the set are easily "zipped" apart for distribution as indicated both by the color of the copies and the instructions printed on the bottom margin of each copy. Almost all answers requested on the forms are answerable by either check marks, dates or simple numerical entries; no "essay" type replies are requested. The printing is aligned for typewriter spacing.

Form A—Notice of Admission or Readmission of Poliomyelitis Patient. This form, consisting of five copies, is used at the time a patient is admitted or readmitted for poliomyelitis treatment. The hospital or other agent rendering service is to fill in Copy 1 and the information filled in appears in blue carbon copy form on the other copies. Copies are distributed as per instructions on forms. The chapter will interview the patient's family to decide what financial assistance might be needed. Then, on one of the two copies which go to the National Foundation for Infantile Paralysis chapter, the chapter will indicate what its responsibilities will be in the care of the patient for the 30 day period if the patient requires financial assistance. It will then be returned as certification to the hospital.

Form B — Notice of Continued Poliomyelitis Patient Care. Form B is used by a hospital or other agency to report the need for continued care for up to 90 day periods, beyond the first 30 days certified under the previous Form A. If further care is needed at the end of this extended period, renewal authorization is requested on another Form B. Distribution of four copies is made by the hospital or agency as per instruction on forms. If the patient requires financial assistance, the National Foundation for Infantile Paralysis chapter again certifies, after an interview with the family, what financial responsibility it will assume and returns this certification to the hospital or agency.

Form C — Notice of Discharge or Death of Poliomyelitis Patient. Form C is used when a patient is discharged or transferred to another institution, or when a patient dies. Distribution of the five copies is made in accordance with instructions on the forms.

Two uniform billing forms have been prepared also.

Form D — Statement of Patient Care Service Rendered. Form D is a statement to be filled in by the hospital or other agency rendering service at the end of each month for each patient whose care is being paid for, in whole or in part, by a national foundation chapter and must be submitted for reimbursement by chapters.

Form E — Statement of Hospital Services Rendered by Emergency Recruited Personnel. Form E is a statement to be used by hospitals to bill chapters for services rendered to poliomyelitis patients by emergency recruited personnel previously authorized by the chapter in accordance with national foundation policies, as described on the back of the hospital copy.

The revised patient care forms will be distributed to hospitals by the national foundation's state representatives in time for use early in July.

FLOOR MANAGERS lift the burden from the nursing department

THE thousand and one nonnursing duties of the overburdened trained nurse are being deftly and capably lifted from her shoulders in an adventurous departure in hospital administration recently instituted at Spohn Hospital, Corpus Christi, Tex. "Back to the bedside with the trained nurse" is the rallying cry of the hospital's floor manager system, which relieves the nurse of 50 per cent of her extracurricular responsibilities, while improving the patient's comfort and the general organization of hospital life.

The floor manager, as she is found at Spohn Hospital, is a combination trouble-shooter, housekeeper, and handholder, depending on whether she is dealing with personnel or with patients. It is within her province to check each room for cleaning before a new patient is moved into it, to order a new light fixture or a new ashtray, to arrange for a fresh, more attractive color scheme when a room is to be repainted, to call for a magazine and a pack of cigarets from the drugstore for a disconsolate patient, to listen compassionately to his troubles and his complaints. She assumes the nonnursing duties and responsibilities which have heretofore burdened the trained nurses. She is responsible for ordering, checking and distributing supplies, for maintaining immaculate order in rooms and corridors, for cooperating with the hospital maintenance crew to ensure smooth functioning in every emergency.

The floor manager's advent was eyed with suspicion by doctors, trained nurses, even patients. It seemed such an excellent idea, and so practical a solution of multitudinous problems, that there must certainly be a flaw in it somewhere! To date, after several months, the flaw has not appeared, and doctors and nurses who were at first apathetic if not downright antipathetic have come to appreciate the cheerful, capable women who pour oil on troubled waters and seem almost magically able to bring about a "happy ship."

Working directly under the administrative department, the floor manager's contact with the patient begins the moment he arrives on her floor; it is she who takes him to his room and notifies the head nurse of his arrival. She has made sure previously that his room is in apple-pie order, and she is able to give him a personal welcome which takes away any fear of sterile institutionalism in his mind. Without ever invading the nurse's province of strictly nursing duties, she is able to perform a hundred small services for him: an extra blanket, a soft drink from the machine down the hallway, a shoulder to weep on, if necessary.

Meanwhile, her relations with the floor nurses and the head nurses remain excellent. She is cooperative and agreeable (indeed, "getting along with people" is the main requisite for the job). She is able to direct her staff of helpers in the mechanics of good housekeeping, without interfering with nursing routine, or disrupting nursing procedure by invading rooms for cleaning at inconvenient hours. Necessary supplies are on hand when called for; repairs are made when needed. The floor manager reports directly to the administrative department for its evaluation of suggestions for improvement in efficiency and service which come within her ken.—SISTER MARY VINCENT, *administrator, Spohn Hospital, Corpus Christi, Tex.*

It Was Human Relations All the Way

at the Tri-State and Mid-West Hospital Conventions

TRI-STATE HOSPITAL ASSEMBLY

CHICAGO.—The milk of human kindness was at high tide during the 22d annual Tri-State Hospital Assembly here last month. Human relations were uppermost in the minds of hearers and tipmost on the tongues of speakers throughout the three-day meeting, which attracted more than 7000 registrants from Illinois, Indiana, Wisconsin and Michigan—the four states in the three-state assembly. In addition, many hospital people came from near-by states like Minnesora, Iowa, Ohio and Kentucky, and there were a few visitors from such far away places as New York and California.

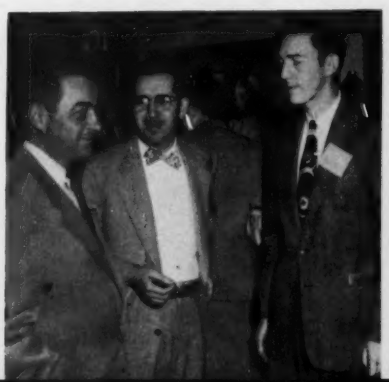
Wherever they came from, they went home impressed, if not burdened, by the administrator's awesome responsibility for making workers happier and more productive and sweetening matters up generally between man and man. Like a missionary handing out Bible tracts, the administrator must deal smiles and kind words out to all hands, several speakers explained. Leadership by command is for the birds; hospitals require leadership by persuasion, a rôle which calls for, among other qualities actually named by human relations experts on the program, education, knowledge, experience, wisdom, vision, courage, imagination, common sense, good judgment, keen perception, sensitivity, realism, high ethical standards, faith, hope, charity and a fine sense of public relations.

Understandably subdued by these revelations of the staggering dimensions of their jobs, hospital people at the meetings this year did not indulge in free-style backtalk to the extent which has always been characteristic of the Tri-State Assembly—a group noted for recrimination. The Monday evening general session, for example, an occasion on which Discussion Leaders Robin Buerki and James A. Hamilton have often traded insults with the audience until hot argument flared, never got off the ground this time. After brisk opening talks by Hamilton on the function of voluntary accrediting agencies in a democratic society and Everett Jones of Chicago on the need for higher medical standards in hospitals, 34 different speakers representing the various sections of the assembly got up and told what their particular departments and interests hoped to gain from the new joint accreditation program, an endless and exhausting recitation which was neatly summed up next day by Veronica Miller of Chicago's Henrotin Hospital: "Everybody wants out of the basement," she said.

Dreary for the most part in spite of the Buerki-Hamilton efforts to stir up the animals, the accreditation session did come to life once or twice in sharp bursts having to do with standards of medical practice in the hospital. Hospital boards, staffs and administrators should insist on strong, positive medical standards, Everett Jones declared, and the way to get better standards is through medical audits. "Let's hope the newly organized accreditation commission will put major emphasis on medical audits and let someone else worry about whether or not the back stairs are clean," he concluded. Dr. Buerki and Dr. Josiah J. Moore, Chicago pathologist, agreed with Jones that all hospitals should have medical audits but emphasized that it is a small minority of doctors who are responsible for the catalog of medical abuses listed by Jones. Nevertheless, "I want the work of every doctor doing surgical procedures studied by other members of the medical profession," Dr. Moore stated. "And don't think surgeons are the only derelict doctors on the staff," he added. "The work of all the doctors needs careful auditing. If we don't have medical audits we might as well close our hospitals, and if the accreditation commission doesn't make us have medical audits, then *they* might as well close up!"

But you can't cram audits down med-

Left: Alida M. Jacobson and Florence Vrooman of Green Bay, Wis. Center: Visitors from Ohio included M. J. Thompson, Jack Hahn, and Paul Sodt. Right: Visitors from still farther away were Sister Theodora, Salt Lake City, Utah, and Sister Mary Florentia, Enid, Okla.





Left: Frank Hampton, Iowa; Harry Panghorst, St. Louis, and Lt. William R. Ramsey, Ohio. Center: Barnard Lorimer from Michigan with Clyde Reynolds of Chicago. Right: The Moellers, father and son Victor. E. C. Moeller (at right) received the Indiana Award of Merit.

ical throats, Dr. Kenneth Babcock of Detroit warned in another session. "The doctor is naturally a rugged individualist —and I do mean rugged," he said. Activities like the medical audit and tissue committee must emerge naturally and never be forced, Dr. Babcock insisted. Moreover, the teaching basis of these programs should be emphasized, rather than any "police action" concept. "We must get the doctors to see things our way," Dr. Babcock said. "We must do most of the giving and adjusting, working closely with certain key figures who can influence the rest of the staff."

By the time Dr. Babcock said it, this kind of talk was as familiar to the convention as *Blacksmith Blues* is to the saloon trade. The full, definitive treatment on human relations had already been administered by Dr. Earl Planty of New Brunswick, N.J., personnel counselor for Johnson & Johnson and a member of the American Hospital Association's commission on human relations. In an hour-long address which kept the customers interested and entertained most of the distance, Dr. Planty spelled out what he said was an unfailing formula for bettering human relations and getting an enthusiastic day-in, day-out response from workers. "Find out what people want—their basic human needs," he said, "then conduct all your activities in such a way that those needs will be satisfied."

The thing that makes it so easy, according to Dr. Planty, is that we all want the same things: a feeling of belonging, recognition, new experiences and security (the kind a loving mother gives her baby, that is, not the kind that comes in envelopes). Gushing good will like an Oklahoma oil well, Dr. Planty suggested a lot of ways in which employers can make certain their employes are getting these four essentials. As somebody pointed out, it all added up to the Golden Rule, with overtones of Groucho Marx, but for many who heard it Dr. Planty's performance was unquestionably the high tide of the assembly.

At one point, however, Dr. Planty's dictum collided head-on with the view expressed earlier in the convention by another human relations genius, Dr. Rollin Posey of Northwestern University, who addressed an opening day luncheon sponsored by the American College of Hospital Administrators. People don't like change, Dr. Posey stated, warning executives that necessary changes must be introduced gradually, lest employes become upset. Dr. Planty, on the other hand, listed new experience as a basic human want and said changes are needed to keep people interested in their jobs. As friend prepared to square off against friend and schizophrenic disaster threatened, a quick-witted reporter came up with a solution to the impasse: "Some people like change, and some don't," he said.

Elsewhere in their discourses, Posey and Planty were as indistinguishable as Castor and Pollux. The effective administrator knows that people tend to remember their successes and forget their failures, Dr. Posey said. "So remember their successes, and mention them!" he urged. Moreover, every worker must have specific, attainable goals. Some need daily goals, he explained, while others are satisfied with longer-term objectives. But the administrator must know how to "stretch the man from one goal, and one success, to another." A good administrator, Dr. Posey concluded, is "essentially an artist" —a keen observer, responsive to the moods of others, sensitive to intangibles, communicative. Finally, "The successful administrator must be a good actor. Subordinates tend to glorify the boss and make him a symbol of the organization. He must live up to this symbol at all times."

Thinking pleasantly of themselves as symbols, hospital executives prowled the rooms and corridors of the Palmer House, arriving late for meetings and often leaving abruptly in the middle of a speech. This restless mobility brought forth a weird announcement from Frank Carr, president of the Wisconsin Hospital Association, who was presiding on the opening day. "The American College of Hospital Administrators is having a luncheon," President Carr an-

Left: E. I. Erickson, president of the A.C.H.A., and Past President Arthur C. Bachmeyer. Center: Sister Mary Ellen, president, Indiana Hospital Association. Right: Wisconsin's President Frank Carr and Anthony W. Eckert, Perth Amboy, N.J., who was a guest speaker.



Left: Erwin Wegge, Illinois president, and Dr. Martha O'Malley, Indiana State Department of Health. Center: Frank Shank, Robert Bachmeyer and Andrew Pattullo investigate an exhibit. Right: Dewey Lutes of Rhode Island and Warren Von Ehren, American Medical Association.

nounced at mid-session, "for the benefit of those who came in late."

Those who came early and held still long enough saw some sparks fly at the meeting on nursing education and service. Leading off with some plain talk on nursing economics, Stuart Hummel of Joliet, Ill., pointed out that the present cost of nursing education ($1500 to $2000 for the three years) is going up steadily as theory crowds practice out of the classroom and affiliations proliferate. As these costs become increasingly difficult for the hospital to carry, accreditation authorities want more nursing teachers with advanced degrees, Hummel explained, and hospitals must pay higher salaries for such teachers to maintain their standing. Inevitably, he said, some schools would fail to receive accreditation, and some would close, at a time when the need for graduate nurses is increasing.

The substitution of auxiliary personnel for graduate nurses is more a matter of necessity than a proper solution, according to Hummel, who described bedside care provided by auxiliary nurses as "unreliable and costly." He proposed a new approach to nursing education which would begin with a year and a half of hospital study, with fewer subjects and less theory than at present, producing a "hospital nurse" capable of performing adequately at the bedside. Others might continue with special training or advanced study which would be carried on primarily by educational institutions rather than hospitals, he suggested. One trouble with the present system was that the nurse's aide and practical nurse had no opportunity to advance to higher positions and thus lost something in job satisfaction, a situation which would be improved under the changes he proposed, Hummel said. "We have too many workers in dead-end streets," he declared.

That did it. First on her feet as Hummel sat down was Marion Wright of Detroit's Harper Hospital. "We get a lot of people who aren't interested in careers," Miss Wright said. "Nurse's aides usually don't aspire to be nurses and often don't have the ability to go on, but they are successful in lesser jobs. We can't all be leaders."

Responding to Miss Wright and others who disagreed with him, Hummel reiterated his view that hospitals would lose their best workers, in nursing and other departments, unless everybody had an opportunity for advancement. "The janitor must be able to become chief engineer," he insisted. Agreeing with the principle of opportunity for all, many administrators in the audience nevertheless shuddered as they thought of their janitors running the power plant or bossing the maintenance crews. On some people, the symbol of leadership doesn't look good.

The symbol of leadership worn by most of the women attending the fourth annual conference on hospital auxiliaries was a bright new straw hat. Conference attendance was lower than last year's, but the E.E.Q. (Eagerness and Earnestness Quotient) was higher than ever. Valuable as hospital auixiliaries are in organizing and performing volunteer services and raising money, their chief contribution is in public relations, the conference agreed. But, "The women can't inform the public unless the hospital administrator informs the women," Mrs. Gus McPherson of Battle Creek,

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TRI-STATE KEY WINNERS

KEYS for meritorious service to the sick and injured were presented to nominees from each of the sponsoring states—Illinois, Indiana, Michigan and Wisconsin. The awards were presented by the chairman of the assembly, Dr. Malcolm T. MacEachern, director of professional relations of the American Hospital Association.

The Illinois award winner was L. C. Vonder Heidt, administrator of West Suburban Hospital, Oak Park, since 1926. Previously Mr. Vonder Heidt was for two years superintendent of John B. Murphy Hospital, and from 1912 to 1920 he was secretary to Dr. W. J. Mayo and later administrative assistant at the Mayo Clinic.

The Indiana award winner was E. C. Moeller, administrator of Lutheran Hospital in Fort Wayne since 1929. He has never missed a Tri-State Hospital Assembly. He has served the Indiana State Hospital Association in many ways, including the presidency. He is a past president of the Lutheran Hospital Association of America and has been chairman of the Fort Wayne Hospital Council since 1933.

The Michigan Award winner was Mother Mary Carmelita Manning, R.S.M., Director of Hospitals, Sister of Mercy Province of Detroit, for the last six years. In her absence John Powers received the award for her. Mother Carmelita Manning was for five years previously Mother Provincial, Sisters of Mercy, Cincinnati, covering six states. She was a member of the Advisory Council to Michigan State Office of Hospital Association for five years, and a member of the legislative committee of the Michigan Hospital Association for two years.

The Wisconsin award winner was Joseph G. Norby, administrator of Columbia Hospital, Milwaukee, for the last 15 years, who is planning to retire from that position about July 1, but not from interest in hospital activities. Mr. Norby went to Wisconsin from Minnesota, pioneered the Blue Cross movement in Wisconsin; he has served as president and trustee of the American and Wisconsin hospital associations and was also a regent and president of the American College of Hospital Administrators.

MID-WEST HOSPITAL ASSOCIATION

KANSAS CITY, MO. — If there was anyone in attendance at the Mid-West Hospital Association's large (1856) and lively meeting here in April who does not know by now that his major problem is People, he just wasn't listening. He was told so in the general sessions by Dr. A. J. J. Rourke, A.H.A. president; by Hal Perrin, new president of the Mid-West association; by Dr. A. F. Branton of Chattanooga; by Ray E. Brown of the University of Chicago Clinics; by Dr. Robert F. Brown of St. Luke's Hospital, Chicago, and by Prof. Clifford Houston of the University of Colorado. He heard about it at the small hospital sections, at the auxiliary meetings, the housekeeping sessions, the record librarians' sessions (their problem is doctors), and at the dinner in honor of the Catholic Sisters.

He did *not* hear about it at the annual banquet because the Mid-West Hospital Association operates on the humane principle that banquets should be speechless.

Even speakers on such subjects as Blue Cross payments and the laws governing hospitals got back to the fundamental human equation: understanding the other fellow's problem.

Lack of understanding on the part of legislators is undoubtedly the cause of some of the burdensome laws that currently afflict hospitals, according to Hubert Hughes, administrator of General Rose Memorial Hospital, Denver, who opened the first general session.

As a prize example Mr. Hughes cited Colorado's Medical Practice Act which provides that any physician ". . . who practices medicine as partner, agent, employe . . . or in joint adventure with any person . . . who does not hold a license to practice . . ." is violating the law. And any person found guilty shall be punished by a fine of from $50 to $500 and imprisonment for from 10 to 30 days for each such offense. Boiled down, said Mr. Hughes, that means that half the doctors and administrators in the state are overdue in the county jail, inasmuch as hospitals that employ specialists, and doctors who accept such employment, among others, can be construed to be in violation of the act.

Left: President Hal Perrin of the Mid-West Hospital Association and, right, Harry J. Mohler, St. Louis, president-elect.

"If we are to have laws in the future under which hospitals must operate," Mr. Hughes urged, "let us cooperate with the agencies which pass these laws so that they will be livable when they are passed."

The success of the hospital accreditation program also depends on people, said Dr. Anthony Rourke. If it is a success, he stated, the program should mark the beginning of a period of activity that will carry hospitals forward to new areas of excellence far beyond any minimum standards set by the accreditation commission. In order to be a success, the commission (and all hospitals) must never lose sight of the primary goal: better patient care.

"If the commission is the graveyard of ideals discarded in the interests of compromise [among the five constituent bodies], it will fail," he asserted. Nor does Dr. Rourke see the accreditation program solely as the "best antidote to socialized medicine," as one hospital magazine writer had put it. "If that's all the program means, it will fail," he reiterated. "The function of the accreditation commission is not to police hospitals; it is to educate, to demonstrate, to lead the way," he explained.

Employer-employe relationships were discussed with passionate oratory by the Rev. Austin E. Miller, S.J., director, Creighton Institute of Industrial Relations, Omaha, Neb., and with dispassionate objectivity by Professor Houston of Colorado. Speaking at the dinner honoring the Catholic Sisters, Father Miller proclaimed the right of employes to consideration of their dignity not only as individuals but as a group and begged the members of the audience to raise the iron curtain between employer and employe.

"We see each other in caricature, not in character," the speaker continued. "The boss is a bum to the worker, who is a welsher to the boss." This unhappy situation will obtain, Father Miller insists, until all groups realize they are interdependent, that in the words of the songwriters, "we need each other." Brandishing the microphone like a

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1952-53 OFFICERS

President: Hal Perrin, Bishop Clarkson Memorial Hospital, Omaha, Neb.

President-Elect: H. J. Mohler, Missouri Pacific Hospital, St. Louis.

1st Vice President: Marvin Altman, Sparks Memorial Hospital, Fort Smith, Ark.

2d Vice President: Carl C. Lamley, Stormont Hospital, Topeka, Kan.

Treasurer: Francis J. Bath, Business Manager, Creighton Memorial-St. Joseph's Hospital, Omaha, Neb.

The speaker's table at the dinner honoring Catholic Sisters. Left to right: Mrs. Francis J. Bath, Hal Perrin, Francis J. Bath, Kenneth Wallace, the Rev. Austin E. Miller, S.J., Sister Rose Irene, Dr. A. J. J. Rourke, Mrs. Wallace, Most Rev. Edwin V. O'Hara, Bishop of Kansas City, Mo., diocese; Howard Baer, Hospital Industries Association, and Celeste Kemler.

Columbus Surgeons Took the Cure for FEE-SPLITTING

GREER WILLIAMS
Public Relations Director
American College of Surgeons
Chicago

THE constitution and by-laws of the Columbus Surgical Society, as adopted May 29, 1946, for some pages are as dignified and dull as those of any other similar professional or trade organization. The objects of the society, for example, are to "maintain an organization for the mutual advancement and welfare of its members"; "to exchange and disseminate information among its members as to the improvements, processes and advancements of the medical profession"; "to foster a spirit of good will among its members, and to promulgate ethical practices in their relationship with each other and the public to the end that all interests may be served fairly."

The section on membership limits the society to "those Doctors of Medicine practicing surgery or surgical specialties in Columbus, Ohio, and vicinity," and specifies, "The Society shall be the sole judge of the qualifications of its members." Any violation of the society's rules, of course, may mean that "membership shall terminate."

DUTIES OF AUDIT SUPERVISOR

In the discussion of the duties of the various officers, nothing of special note emerges until one elected officer, the audit supervisor, is mentioned. As chairman of the auditing committee, he is administratively responsible for "completion of the annual audit as soon as possible after March 15." Furthermore, "He shall . . . stand ready to hear and investigate complaints of any member reporting evidence of irregularities."

It is not clear at this point in the by-laws what the audit is, or what irregularities might concern the audit supervisor. In the subsequent discussion of the society's legal counsel, its governing council, its expenses and its quarterly meetings, the matter remains a mystery. The section on discipline is rather severely phrased, we note, in terms of *charges, complaints, suspension* and *expulsion.* It provides that "If a member wishes to refute charges, he may do so before the Council, or before the Society. . . . At such a hearing the results of the audit of the accused member's books may be presented at the discretion of the accused or of the Society."

On page 18, in the section on Ethical Standards, the meaning of membership in the society takes definite shape. The candidate for membership, it is stated, must sign an agreement to refrain from fee-splitting and to accept as correct the American College of Surgeons' definition of fee-splitting.

Perhaps, then, this is an organization to combat fee-splitting.

Fee-splitting takes many forms, and has been defined in various ways, but it is essentially the secret division between two doctors, ordinarily one doing an operation and another who has referred the patient to him, of the fee paid by the patient. Fee-splitting means, in its simplest terms, the buying and selling of patients on a commission basis.

It is one of the oldest evils of surgery, an outgrowth of competition among surgeons, and of the widely disproportionate fees which a general practitioner and a surgeon may collect from the patient sent by one to the other for an operation. All contentions to the contrary, fee-splitting *is* an evil. It does not, admittedly, reflect the surgeon's technical competence or lack of it. It does, however, involve his moral competence; through this financial inducement he seeks to influence the referring doctor's judgment of who is best qualified to do his surgery.

Fee-splitting frequently leads to overcharges and to unnecessary surgery, both costly to patients. Its existence—and it has been common practice in many, but by no means all, sections of this country—is *prima facie* evidence of dishonesty. It is patently dishonest because the splitting of a fee is usually completely concealed from the patient. Concealment enables the errant "family doctor" to depend on the surgeon for his compensation, and thus either bill the patient for a negligible fee of his own or, as one doctor described it, "take a long bow" for his magnanimity in apparently foregoing a fee altogether.

KEPT SECRET FROM PATIENTS

Obviously, an unearned kickback must be kept secret from the patient, because knowledge that such an inducement existed would shake his trust in his physician. He needs to trust him because of the therapeutic effect of faith in one's doctor and because the sick are not in position to pick and choose; they must place themselves at the mercy of the doctors who attend them. A sick man wishes to be removed from the market place and into some sanctuary safe from commercial exploitation.

All of this, of course, has been recognized over and over in medical ethics as well as the laws of the 23 states which place statutory strictures on fee-splitting.

The American College of Surgeons traditionally has exacted a pledge of its fellows that they will not split fees. Hospitals accredited by the college likewise have been required to obtain signed pledges from all medical staff members that they will not split fees.

Ethics, laws and pledges have been approximately as effective as was Prohibition. In various communities, economic need, competitive stress, or long established custom has produced fee-splitting in conflict with the pledge. Some surgeons have gone so far in confused thinking as to argue that the fellowship pledge contradicted their local effort to obey the Golden Rule, which they interpreted as advising them to do unto other doctors as they would be done by; in other words, split fees. This overlooks a more fundamental application of the Golden Rule to the patient.

THEN IT GETS TOUGH

Having committed itself to the American College of Surgeons' view of fee-splitting, the Columbus Surgical Society, on page 21 of its by-laws, suddenly distinguishes itself from all similar societies in very specific, very tough language:

"There shall be an annual audit of the professional records and accounts of each member of the Society, including income tax returns. The accountant or auditor shall be designated and instructed by the Council. . . . The examiner's report shall be strictly limited to the data showing the existence or absence of fee-splitting as defined above. Each member of the Society shall supply the examiner with whatever *waiver* or *permit* he may need to conduct the above examination and to permit him to report his findings to the Society. . . . Failure to permit the audit shall be construed an irregularity and sufficient reason for investigation . . . and disciplinary action. . . ."

These were the formal articles of war on fee-splitting drawn up by the founders of the Columbus Surgical Society in 1945 and mentioned in a previous report (The Truth about Fee-Splitting, The MODERN HOSPITAL, February 1948; *Reader's Digest*, July 1948). The purpose of the present report is, by the same reportorial methods, to follow up on what undoubtedly has been the most spectacular, if not altogether the noblest, experiment in self-policing ever conducted by the medical profession.

Columbus is a city of a half million population, with one medical school. Up until Jan. 1, 1946, a "high percentage" of surgeons and general practitioners split fees. As in other similar communities, the system had become well established over a period of years. As one long-time practitioner in Columbus put it, an intern learned the system soon after graduation from medical school and by the time he was ready to practice had a practical working knowledge of fee-splitting. Usually, he would have been contacted by a surgeon who wanted to establish him as a feeder, or source of surgical patients.

The young doctor going into surgery also learned about fee-splitting, in a somewhat grimmer fashion. Said one who had survived: "Older surgeons would crowd around the younger surgeon and take his referring doctors away from him." It is commonly said that surgeons offer to split fees in order to take business away from others. This is true at the time fee-splitting is introduced in any community, but one Columbus surgeon who learned fee-splitting from the inside said that offering a split placed a surgeon at no advantage in a fee-splitting community, it only gave him an equal chance. "The point is merely that he was at a disadvantage if he did not split fees," said this doctor.

Quite a number of the surgeons were not recognizable as specialists by American College of Surgeons or American Board of Surgery standards of training and experience. Some were of the "homemade surgeon" type who had served apprenticeships under a preceptor. Said a surgeon observer, "Some were good men, but others were trained by masters in all the master's bad habits, including fee-splitting."

None of the surgeons liked fee-splitting; witness the statement of one: "The practice of surgery under fee-splitting was disagreeable. Attempts were made to influence your judgment. General practitioners would bring a patient into the hospital and demand an operation for a condition you didn't think existed. If you disagreed, the G.P. would remark about your judgment to the family in a way to ruin your reputation."

It should be made clear at this point that this statement did not apply to a good number of general practitioners who did not ask for a split or to the number who went further and refused the split when it was offered.

In 1945, two of the city's fee-splitting surgeons agreed that something drastic should be done to stop the evil. In their effort to form Columbus' first surgical society, they were soon joined by three or four others who were also "tired of splitting fees."

In what followed, not only critics of the Columbus Plan, as it became known, but some of the co-founders themselves agree that the reform was not born of high motives alone. As is often the case in life in human form, the well of good deeds may be fed by a spring of selfishness.

Volume-wise and income-wise, one insider noted, the big fee-splitters had reached a point of diminishing returns. The pace of heavy daily operating schedules is, or can be, a killing one as a man gets older. Income taxes were taking increasingly big bites out of the busy fee-splitters' $100,000 to $200,000 grosses. It was high time to do something for the patient and, at the same time, to cease giving away half of every fee. There was no prospect of increasing volume or fees.

HOW THEY WERE CONVERTED

Even so, the co-founders found other fee-splitting surgeons hard to persuade. The reformers worked diligently, however, buttonholing their colleagues and calling them on the phone. They started with those who were easy to convince and gradually maneuvered the more dubious and cynical "into situations they couldn't wiggle out of," as one participant put it. With the tough customers, it got down to a matter of playing one against the other in this vein:

"Doctor, none of us like this kind of thing; let's stop it for good."

"It's been tried before. It's just talk. Everybody signs up and goes on as before."

"We don't need to if we can get men like you to go along with us."

"You know Joe ..... would never fall into line."

"Will you, if he does?"

"I'd think about it."

Mutual suspicion, born of years of sharp competition and lack of a forum where the surgeons could ventilate their hostility toward each other gradually caved in under determined pressure. The first objective was to obtain the surgeon's signature on an agreement to stop fee-splitting and to submit to an annual examination of his patient accounts and income tax return by an auditor.

By the middle of 1945, 76 had signed up, including a good number of A. C. S. Fellows. Eventually, surgeons who had not become "founder members" were taken in on an "all-is-forgiven" basis, making 93 members at the outset. At midnight, Dec. 31,

1945, according to all opinion, the gentlemen of the Columbus Surgical Society with but rare exceptions completely ceased to split fees. They presented the referring, general practitioners with a *fait accompli.*

G. P.'s who did not seek splits remained friendly, but the subsequent year has been conservatively described as one of "tremendous upheaval" for all who had split fees. It should be noted that the effectiveness of the reform was, by coincidence, greatly implemented by the Bureau of Internal Revenue. From time to time, as its officials like to say, the bureau "investigates certain categories of income." It so happened that Columbus physicians' incomes were one of those categories.

The primary interest of the Internal Revenue agents was in uncovering concealed income and evasion of tax; in short, fraud. In those days, they did not stop to question whether a split fee was an allowable business deduction from one's taxable income. Every doctor who made a 50-50 split with another counted the portion paid out as a legitimate and deductible expense of business.

NOT A BUSINESS EXPENSE

To drive noncooperating surgeons into the tax evasion corner, the Columbus Surgical Society in 1946 passed a resolution and notified the Internal Revenue agent that fee-splitting had been virtually stopped in Columbus; therefore, it was no longer a necessary expense of business. As a matter of fact, the society pointed out, anyone who now split fees was taking unfair advantage of his fellow surgeons. In consequence, Columbus became the first city where Internal Revenue agents disallowed split fees as necessary expenses of business. It remained for the agents, of course, to determine whether sums paid out to other doctors were split fees or proper compensation for surgical assistants.

With the Internal Revenue agent and his spot investigations constituting a fortuitous Jove and his thunderbolts, plus the real desire of the surgeons to be done with fee-splitting once they could believe the other fellow was done, too, the Columbus Plan has been able to achieve its aim, from all accounts.

In the first two years of its operation a few "incurables" turned up. There were surgeons who refused to join and double-dealers who joined and kept two sets of books. One way or another, by Jove or otherwise, these five or six were disposed of. Two of the holdouts moved out of town. One died of coronary thrombosis. One came into the society through pressure applied through the hospital where he operated. Now, in contrast, the tactics were not to try to squeeze out a surgeon through competition but, instead, to squeeze him into the society and keep an eye on him. During this period, it acquired the opprobrious nickname of "Columbus Surgical Protective League."

It is instructive to examine the case of one incurable fee-splitter. Doctor X, as we shall designate him, had the distinction of having offered splits as high as 110 per cent of his fee. By this it is meant that he built up "feeders" on occasion by giving a young general practitioner just starting out the entire fee from the patients he referred, plus a small subsidy for living expenses and overhead. After Doctor X got a man started, he would cut him back, perhaps to 85 per cent the next year and finally down to the standard 50 per cent.

At one time, Doctor X ran afoul of his hospital administration when the pathologist reported that he was removing too much normal tissue, which is to say doing unnecessary operations. The supervision was lax, however, and nothing came of this revelation of predatory practice.

But Doctor X also had to contend with the policing tactics of the society, whose policy it was to force membership and hence reform on Columbus surgeons by persuading their hospitals to make society membership a prerequisite to staff appointment. Only two of Columbus' seven general hospitals ever took this action formally. In the others, the surgeons of the society found themselves in control of the composition of the surgical staff at the outset and thence observed the requirement more or less as an unwritten law.

It was this sort of pressure which persuaded Doctor X to apply for membership at the end of 1946, and he was accepted. It was apparent, however, that he had no intention of changing his spots. He continued to split fees and, as the only remaining splitter of any consequence, enjoyed a surgical Klondike as split-seeking general practitioners brought him their patients. He did as many as 12 to 14 operations a day, rarely seeing a patient before he was wheeled into the operating room or after he was carted away. As one close observer put it, "He was killing himself with work."

Presently, in 1947, the Internal Revenue agent appeared like the Raven on the windowsill. He reportedly found that Doctor X, as other surgeons suspected, had been splitting with referring physicians in cash, so that no evidence of payment to these doctors appeared in his accounts or in his income tax returns. This, however, constituted concealment of income. The income investigation continued.

HIS TROUBLES PILED UP

When the society's auditor showed up in December 1947 to review the doctor's ledgers, they were scattered, in the hands of his attorney, lost or unaccounted for. Trouble was beginning to pyramid. Doctor X sat down and wrote a letter of resignation to an officer of the society, charging "personal persecution."

"These enemies of mine in your society," wrote Doctor X, "are exceedingly cunning and vicious. . . . There are a number of men in the society who have in the past taken oath as members of the American College of Surgeons. I feel certain you know they have openly violated the oath of the college. It is my opinion gained over the months that they as well as others are not keeping their word with your organization."

This was an often-heard defense: "I conduct my practice as honorably as the next fellow. *He* should talk!"

While it was obvious that members of the society and of the college had split fees in the past, no evidence has been produced that they were continuing to do so. There was evidence that Doctor X was, and also that he wasn't paying as much tax as his income warranted. The Bureau of Internal Revenue, it is reported, assessed him something in excess of $100,000.

Doctor X, who had already suffered two heart attacks, at first seemed to feel he could work his way out of financial difficulties, simply by operating on more patients. The trouble with this theory was that the doctor could not increase volume without splitting and he could not submit an honest income tax return with splitting. Furthermore, the more he worked the higher he climbed in income tax brackets and hence the less money would be left with which to settle up.

(*Continued on Page* 94)

ABOVE: RENDERING OF PONCE HOSPITAL CENTER. BELOW: NURSES' RESIDENCE

Puerto Rico plans for a

Comprehensive Health Service

ISADORE ROSENFIELD
Architect, New York City

JUAN A. PONS, M.D.: Commissioner of Health
JORGE JIMINEZ: Commissioner of Interior
JULIO A. PEREZ: Director, Hospital Survey and Construction Bureau

PURSUANT to the aims and purposes of the Hospital Survey and Construction Act, Puerto Rico was divided into two hospital areas: one corresponding roughly to the north half of the island and the other to the south half. Each area was in turn subdivided along the lines of coordinated hospital services as recommended by the U.S. Public Health Service.

At the head of each principal area there is to be a comprehensive hospital center containing such facilities as would provide the area as a whole with specialties, and the immediate locale, in addition, with general medical and surgical services.

The plan for the construction of health facilities in the south half of the island (Intermediate Area No. 2) designates the following facilities to be grouped for most efficient service and operation at the city of Ponce:

1. A 400 bed general district hospital
2. A 200 student school and residence for nurses
3. A 500 bed tuberculosis hospital
4. A 1000 bed mental hospital
5. A central laundry (to serve the foregoing and other institutions in this area)
6. Housing for interns and executives
7. Steam plant and other services

ARRANGEMENT ON SITE

The site is a 240 acre tract of sugar cane land situated on the north side of the shore highway, eastwardly from Ponce, on the fringe of its present development. The land slopes from the mountainous background toward the road and faces a range of low hills to the left and the Caribbean Sea and the prevailing breezes in front.

All principal structures face with their long exposures toward the view and the breeze. Those buildings that should be most readily accessible are placed close to the highway and the others range upward on the hillside.

As the center consists of three hospitals so are the buildings grouped in three major components, and the buildings comprising each component are to be built as one operation of three. The first and most important

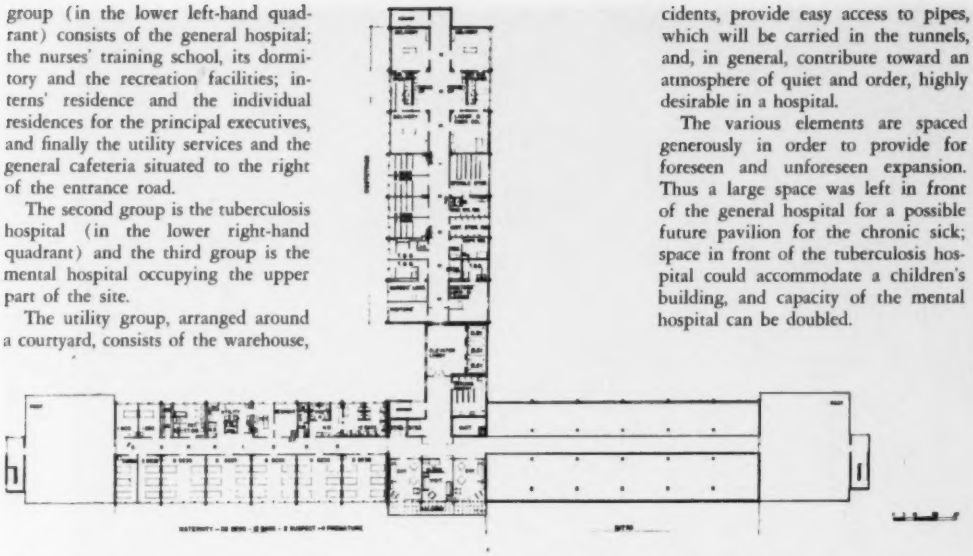
group (in the lower left-hand quadrant) consists of the general hospital; the nurses' training school, its dormitory and the recreation facilities; interns' residence and the individual residences for the principal executives, and finally the utility services and the general cafeteria situated to the right of the entrance road.

The second group is the tuberculosis hospital (in the lower right-hand quadrant) and the third group is the mental hospital occupying the upper part of the site.

The utility group, arranged around a courtyard, consists of the warehouse, laundry, power plant, garage, shops and animal quarters. The cafeteria is central not only to the three hospitals, but also to the utility group, which will employ a goodly number of people.

The principal buildings are connected by tunnels. This is important for the discreet movement of goods, patients and bodies. The tunnels also ensure uninterrupted movement during rain and catastrophic hurricanes, which come occasionally. While tunnels are more expensive than roads are, they save on the more costly ground transportation, avoid traffic accidents, provide easy access to pipes, which will be carried in the tunnels, and, in general, contribute toward an atmosphere of quiet and order, highly desirable in a hospital.

The various elements are spaced generously in order to provide for foreseen and unforeseen expansion. Thus a large space was left in front of the general hospital for a possible future pavilion for the chronic sick; space in front of the tuberculosis hospital could accommodate a children's building, and capacity of the mental hospital can be doubled.



Although the need for hospital facilities in Puerto Rico is urgent, nevertheless it is not practical for fiscal and other reasons to build the entire center in one operation. The following order of construction has therefore been determined upon:

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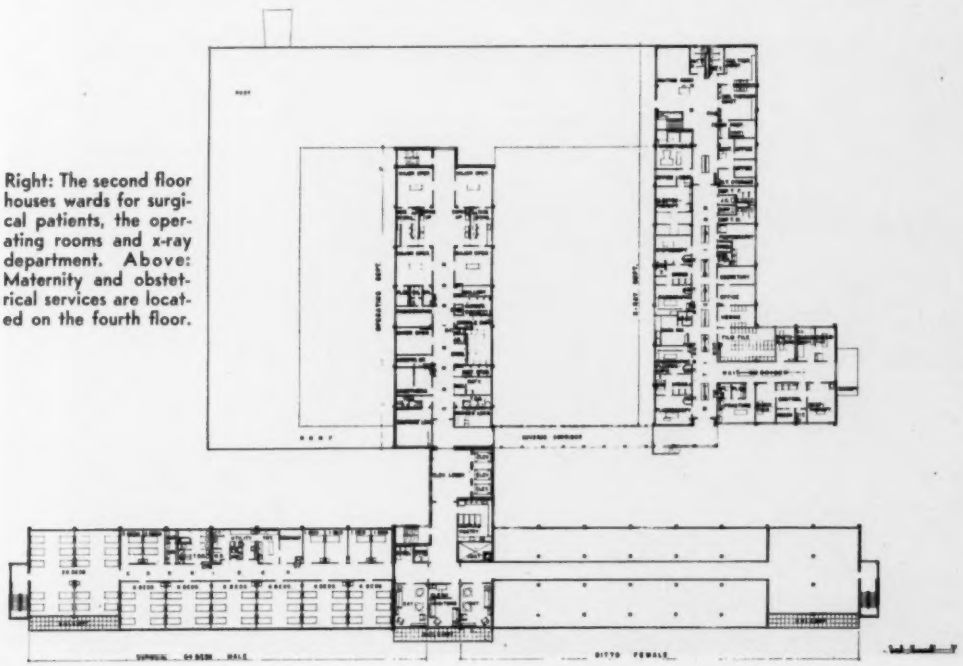
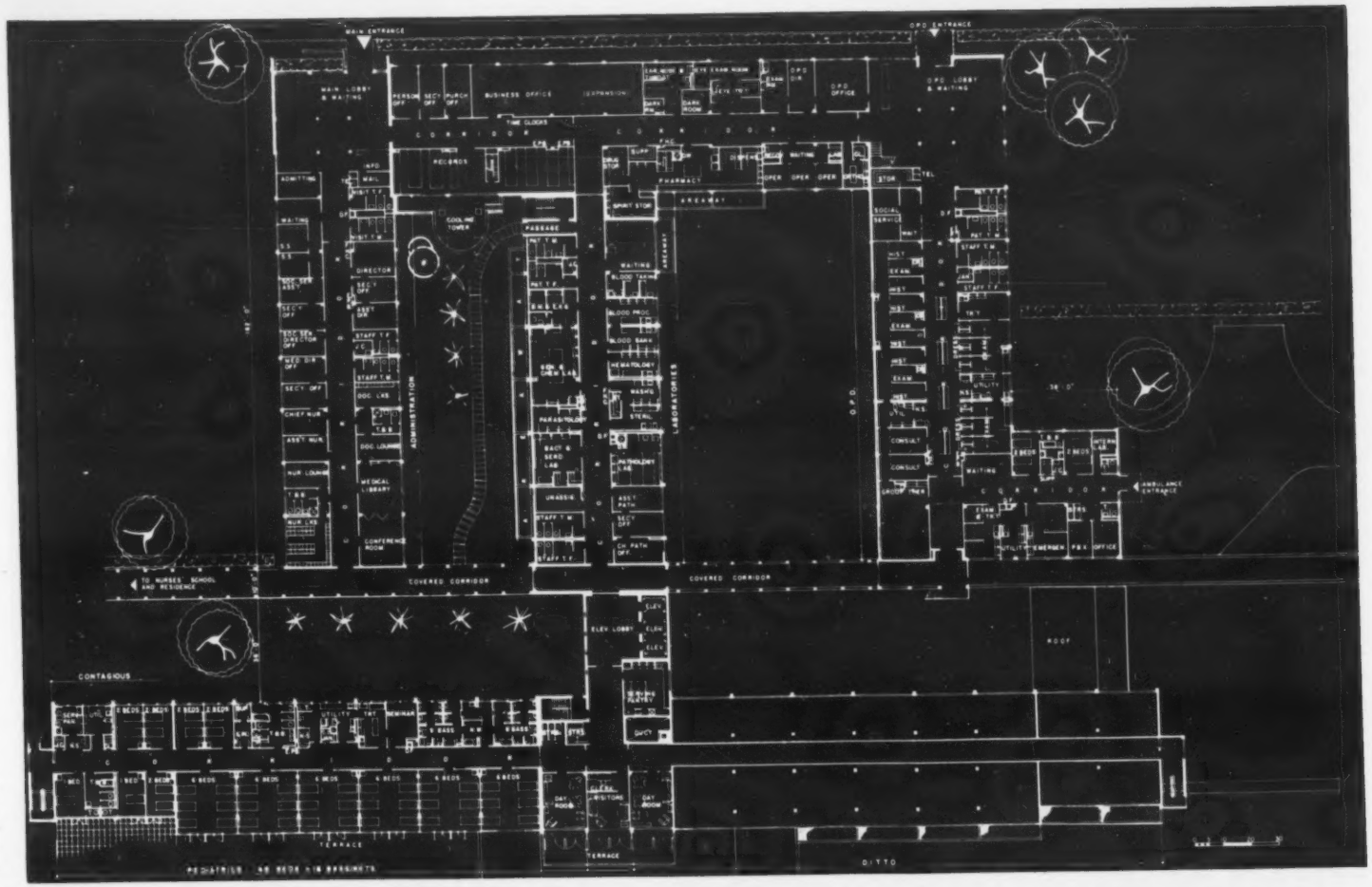
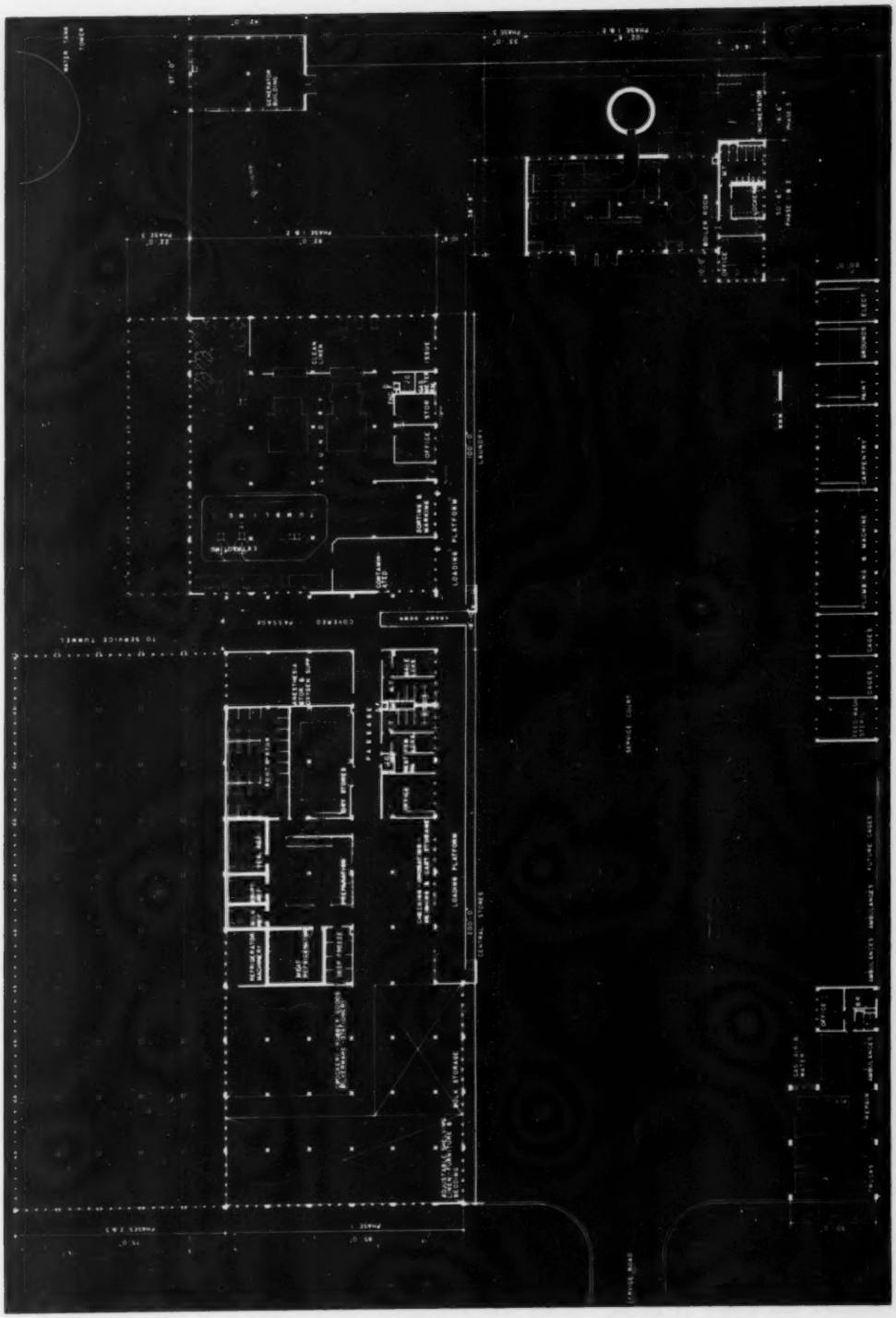


Right: The second floor houses wards for surgical patients, the operating rooms and x-ray department. Above: Maternity and obstetrical services are located on the fourth floor.



Above: Plan of first floor showing layout of administrative unit, laboratories and outpatient department at rear of building, and pediatrics department in the foreground. Opposite Page: Plans of the utility group, including storage areas and boiler room.



(*Continued From Page* 71)

1. The general hospital; the facilities for nurses' training, living and recreation; the residences other than for nurses, the utility group, and the employes' cafeteria. Laundry, warehouse, power plant and dining facilities are also to serve the needs of the first phase, but they have been designed to be expanded along predetermined lines as the other hospitals are added.

2. The second phase will consist of the 500 bed tuberculosis hospital with such additions to the utility and cafeteria group as the added load from the tuberculosis hospital will require.

3. Phase three will consist of the mental hospital with corresponding expansion in the utility group and in the cafeteria.

There are existing hospital centers which consist of general, tuberculosis and mental hospitals and which also have schools of nursing. An example of such a center is Bellevue in New York City. In this respect the Ponce Center is nothing new. However, the Ponce Center is different from other centers of like content in several significant respects.

Existing centers started out as general hospitals and grew with the demands of time. The addition of each new increment involved wrecking something of the preceding increment to make way for the new work. In Ponce we have a center with all elements planned at the outset and in an integrated manner. This means conservation of structure (first cost) and of medical and administrative effort (operating cost). These in turn mean greater benefit to the patient and to the community.

The following are some of the major points of integration achieved: The district hospital will house the central administration for the whole hospital center and will have the major admissions, outpatient, laboratory and necropsy facilities. A patient admitted in the district hospital would either be sent to the proper nursing unit in that hospital or would be transferred via the tunnel either to the tuberculosis building or to the receiving building of the mental hospital.

Patients from the mental hospital requiring major surgical intervention will be operated on in the district hospital and will be kept there in a special nursing unit which is situated immediately over the operating department.

For reasons of asepsis, the tuberculosis hospital will have its own operating department, and this department will also answer the requirements of tuberculous mental patients who may require surgical intervention. For this reason, the tuberculosis unit of the mental hospital is located immediately to the rear of the tuberculosis hospital and is connected with it by a tunnel.

It is obvious, of course, that the service unit with its garage, shops, stores, laundry and steam plant is intended to serve all three constituent hospitals and will afford a major economy in purchasing, distribution and operation for the whole center.

CONSERVE MEDICAL TALENT

The foregoing features of physical integration and proximities imply both avoidance of duplications of elements and also added convenience and economy of operation. They also spell out the conservation of medical talent, which is a matter of paramount consideration in a country with a conspicuous shortage of doctors.

Let us take the case of a neurosurgeon. Normally he would operate in some general hospital and would have to travel a considerable distance to get to the patients at the mental hospital. Here the surgeon does not have to travel to care for the two types of patients. The same would be true of the thoracic surgeon, who would normally have to travel between the general hospital, the tuberculosis hospital and the mental hospital, and these would usually be miles apart.

This same would apply to all specialists. The sad part is that when general and special hospitals, such as mental and tuberculosis, are physically far apart, the patients in the special hospitals do without the specialists.

Causes of Fires and Explosions

THE recent "Survey of Fires and Explosions in Hospitals of the U.S." by Benjamin J. Ciliberti, M.D., and Paul M. Wood, M.D., published in the *American Journal of Surgery* for April 1952, is based on data compiled from questionnaires sent to 6400 hospitals in the U.S. and covers an 11 year period from 1938 to 1949. Of this number, 2285 (35.7 per cent) replies were received.

During the period under survey, 41 explosions and 28 fires, or a total of 69 operating room incidents, were reported. The commonest causes were (a) static electricity, resulting in 32 explosions; (b) suction pressure machines, resulting in 10 fires, and (c) cautery apparatus, accounting for seven fires and two explosions. Additional etiologic factors, which accounted for the other 18 incidents, were "high pressures," plug pulled from socket, short circuit, live cigarets, x-ray, diathermy, mechanical spark, alcohol lamp, and photo-flash bulb.

Of unusual interest is a table depicting the monthly incidents of explosions caused by static. The data therein show that there were 11 cases during the months of October to December, inclusive, and seven cases during the months of January to March inclusive. The second and third quarters had relatively few cases: four and two respectively. October predominated and appears to be the most hazardous month of the year, while no static explosions were reported during the months of May, August and September. (Thoughtful surgeons and anesthesiologists might do well to plan their vacations accordingly.)

The geographic distribution of operating room explosions and fires is of some interest, New York State leading with 21 incidents, Pennsylvania with 10, and Texas with six. New York City alone accounted for 11 and Philadelphia for five. Since the number of anesthesias administered in these localities is not available, no conclusions can be drawn from these statistics.

As expected, 75 per cent of static explosions occurred in rooms without conductive flooring and 59.3 per cent in rooms without any grounding at all. However, the estimated explosion rate is two to four per 100,000 anesthesias administered (which is very small). It is estimated that static electricity will account for approximately eight explosions each year in United States hospitals.

The authors emphatically recommend installation of conductive flooring, grounding, and exclusion of such articles in operating rooms as woolens, silks, sponge rubber cushions and rubber soled shoes."—S. W. FRIEDMAN, D.D.S., *assistant director, Montefiore Hospital, New York City.*

Social Medicine

Hospital Facilities for the Aged

E. D. ROSENFELD, M.D.
Executive Director
Long Island Jewish Hospital
Queens, Long Island, N.Y.

TO PLAN medical facilities and services for the aged, we must first have some concrete ideas as to how good medical care can best be achieved. In most areas of this country adequate medical and hospital services for the aged, particularly for those in old age, convalescent, nursing and boarding homes, do not exist. Either new facilities must be created or the present inadequate system must be modified and expanded to meet the growing needs of a progressively aging population.

I take it for granted that our goal is the achievement of comprehensive medical care, and that for the aged patient a greater concentration of facilities and more highly developed research interest in the degenerative diseases are needed if this goal is to be achieved.

A JOB FOR GENERAL HOSPITAL

An expansion of facilities for such a program is only possible, to my mind, within the framework of the general hospital, and then only if it is coordinated and integrated with the various community services and resources that are concerned with prevention, public health, social, clinical and laboratory research, education, rehabilitation and health maintenance. This job can best be done under the auspices of the general hospital, because only here are concentrated the necessary technical resources and trained personnel. Separate institutions for the aged or the chronically ill (often, mistakenly used synonymously) do not attract the required scientific personnel nor do they have the funds to develop a comprehensive care program. Only one voluntary general hospital for prolonged illness, to my knowledge, has attempted such a program; in the process it has grown into a first-class medical center, not alone a hospital for chronic diseases. I refer to Montefiore Hospital in New York City.

A geographical redistribution that brings together in one functional unit all the facilities and services needed for the medical care of a population group, thus forming a comprehensive community health center, is necessary for a successful attack upon the problems of the aged ill. These facilities and services might be functionally related, as shown in figure 1. Depending upon an individual's medical and social needs, comprehensive medical care might be rendered upon an ambulatory basis by any one of the facilities in Group B (Fig. 1). The patient using these facilities might live in his own home or in the old age home—one of the three inpatient facilities in Group A, shown at the top of the chart. (See page 76.)

Patients should be referred from one to another of the facilities freely as their needs dictate. Aged patients in residence here or in their own homes must have immediate access to the inpatient nursing units when occasion demands. No matter where the patient might reside or through which facility he might receive care, he would benefit from the easy access and proximity of the diagnostic, therapeutic, research, educational, administrative and social services that serve the entire health facility. These are listed in Group C (Fig. 1). Some patients, both old and young, who for medical, social or other reasons are best cared for in their own homes, would benefit from the home-care facilities of the community health center, either as indigent or as private patients, and at the same time would relieve bed shortages. The whole system must be a flexible one.

This scheme does not disturb the socio-economic pattern of medical care, and it brings together into one functional unit the various components of comprehensive medical care so they can be most effective in any given community. For the proper performance of its functions, each facility in Groups A and B needs the services listed in Group C (Fig. 1), in whole or in part. To create such services for each of the small independent agencies in Group A and B, independently, is prohibitive; to create them together and to share in their usage is economically feasible and creates one of the important bases for high standards of medical care, namely, adequate and comprehensive facilities.

DEPENDS ON POPULATION

The extent of development of such a community health center would depend upon the size and nature of the population group it is intended to serve. In sparsely settled areas a number of communities might combine resources to achieve it. Such a center, in turn, might well be affiliated with a larger medical center in a more urban area.

An architectural plan such as outlined here has been created by the architect, Joseph Neufeld, as a project of the school of design at North Carolina State College* for a town of 15,000 people. Figure 2 shows the grouping of facilities as they developed prior to actual plot planning. This is a functional as well as a special relationship. (See page 77.)

The central building is the core containing the diagnostic, therapeutic, laboratory, research, administrative and

From a paper delivered at the second International Gerontological Congress, St. Louis, September 1951.

* Progressive Architecture, (July) 1951, pp. 86-91.

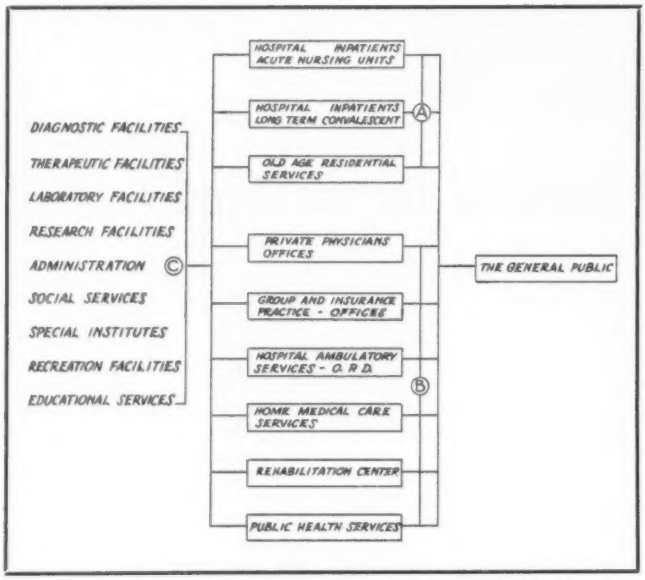


Fig. 1: Comprehensive Medical Care in a Community Health Center.

social services. Surrounding this core a grouping of facilities, beginning with the ambulatory units, was developed: the private practice offices, or group and insurance practice offices; the outpatient facilities; the ambulance services of the community, and the home-care services. In close proximity are the nursing units for both short-term and long-term patients. A convalescent unit might be included.

Using the core's services is a rehabilitation and social center containing physical therapy, occupational therapy, and ambulatory psychiatric services. Speech correction, vocational guidance, and community recreational, social and group activities might be centered in such a unit as well. Also using the facilities of the core, particularly the laboratories, is the local public health unit which performs preventive medical services, including immunizations, prenatal and maternal care, cancer detection, periodic health check-ups and mass surveys, in addition to sanitary inspection and the like. It should serve as a public health educational center and have classrooms and an auditorium for this purpose. It should attract the private physician and make its facilities available to him.

To complete the picture, the residential facility for the aged, not the aged ill (who belong in the nursing units), is on the same grounds. It has its own recreational and workshop facilities but makes maximum use of the concentration of skills and services that are near at hand and freely refers its people to them for care. Some administrators, particularly of old age homes, may object to the close proximity of the residential services to the diagnostic and therapeutic facilities on the grounds that the well aged will resist the implication of "sickness" associated with such proximity. An educational project is needed here.

As will be noted, the term "hospital" is not applied to any unit of the health center. If people are educated to the total health concept and learn to use such facilities, they will welcome closer integration for the promise it holds of greater and less expensive services, of emphasis on prevention and rehabilitation, and, finally, for the hope it gives of more productive and less dependent old age. On the same grounds are included the community athletic and recreational facilities. Total health must include recreation for all groups.

There is no routine set of standards by which an architect or planner can create a well integrated, reasonably efficient, and workable physical plant. Projects of this type take many months of research, drafting and engineering work. Physicians, nurses, social workers, technicians, department executives, and important community leaders interested in its activities or who may work in the center need to be consulted step by step as plans progress.

The administrators should be intimately associated with the plans long before they reach the blueprint stage. Consultants with experience in planning are needed, not to replace but to supplement the administrator's and the local architect's advice. A planning board of professional staff members, acting upon the authority of the responsible agencies, should be set up and should carry the major burden of the functional plan. Attention to details by both the architect and the planning board will net important dividends in the quality of the facilities created. Such plans should not be hurried nor should the plans be too severe or rigid. Flexible plans and programs are required in this day of changing concepts. The natural tendency to compromise with quality when budgetary requirements are faced must be resisted.

Where should such a community health center be located? It must be easily accessible to and close by the population it is to serve. This means good traffic arteries and readily available public conveyances. Congested and industrial areas should be avoided. A flat plot of land, with an attractive view and freedom from obstructions to breeze and sun, is desirable. The land area must be large enough for present needs and reasonable future expansion. It should include enough acreage for recreational and parking facilities, as well as gardens and lawns. No more than 15 per cent of the surface should be covered with buildings. Zoning regulations, to prevent crowding upon a health facility, are needed.

The importance of open, accessible and flat acreage cannot be overemphasized and must take precedence over other considerations. To acquire this kind of land, however, often requires more fortitude than planners have shown heretofore in resisting the dictates of expedience. The continual increase in the numbers of older people and the expanding demands for comprehensive medical services mean planning for growth and expansion. Only by insisting upon adequate sites will growth be possible.

In planning for medical service that will be used by all segments of the population, it is logical to design first for the old people and for those with

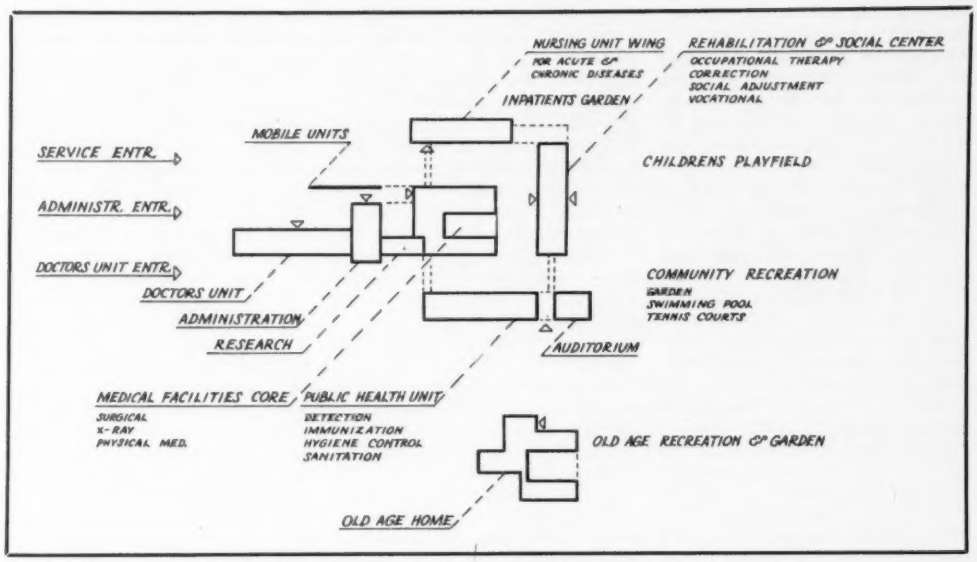


Fig. 2: Grouping of facilities as they developed prior to actual plot planning.

prolonged illnesses. The young and the acute, when in need of medical care, can readily use facilities and equipment designed for these groups. The reverse is not often permissible under the prevailing policies of acute general hospitals, however desirable it may be. We must give special attention to certain layout and equipment items that might be overlooked.

Every effort should be made to reduce corridor distances whether in the old age residence or in the utility and nursing units. The shortage of trained personnel in all classifications, particularly nursing, requires more reliance on mechanical communications and shorter distances for maximum efficiency and better quality of care. Research is needed in design and layouts, so that the architect can create units with shorter communications but of sufficient size for good administrative and supervisory control.

Corridors must be wide enough for wheel chairs, stretchers and beds. Eight feet is the generally accepted width. Handrails along the corridors have been omitted from most recent plans, but they are useful in any building that serves aged or ill persons. Doors also should be wide enough to allow for the passage of beds. Forty-two inches is the minimum width acceptable for this purpose. Doors are often too heavy or hardware is too light to allow for easy opening and closing by enfeebled persons; they also are often a burden to the nursing staff. Architects should pay more attention to the problem presented by doors which, because of their necessary width, become too heavy for ease of operation.

We often see ramps and stairs in both hospital and old age facilities, particularly when terrain is hilly or when the architect has not been able to solve certain design problems without them. Neither ramps nor stairs should ever be allowed if the plan requires their routine use. Stairs, of course, are required for fire exits, but vertical movement should be accomplished by elevators in any multistory building housing the ill or aged. Approaches to the buildings should also be flat from the point where vehicular traffic ends and pedestrian traffic begins. Let us not forget that the hearts and vascular systems of our patients are frequently overstrained.

Elevators must be provided with doors large enough to allow for the passage of beds and should be quiet, self-leveling and capable of both operator and self-operated control. The doors should be operated by air compressors and provided with longer opening times when self-operated, so as to allow time for the slow moving aged or infirm person to get aboard. Slight resistance to closure should automatically reopen the doors. Safety in design and operation is required when one is planning for the ill and aged. The importance of fireproof construction and of adequate fire fighting and signal systems is self-evident, yet too often compromised even in new construction.

The fixed and movable equipment of such a health center needs particular attention. Toilets, lavatories, sinks, beds, tables, chairs and lamps should be of sturdy construction, both for low maintenance and long life, but particularly because cheap furnishings and equipment are a danger to life and limb when used by people whose reflexes are slow. Free standing floor lamps must not be used. Lamp bases fixed in tables are very good.

Furnishings that can be built into walls are far more satisfactory in a center of this type, even though they do not allow the same flexibility of use as do portable furnishings. They last longer, need less repair, and create less of a maintenance problem. Also they are safer.

Adequate closet, locker and storage space in all rooms and utility areas seldom are found in most modern construction. A glimpse at the patient areas in almost any hospital or old age home will suffice to prove that patients will always accumulate more personal belongings than the storage facilities available can accommodate.

Hand grips at all strategic points, near toilets, bathtubs, settees, chairs and tables are needed and should not be forgotten. Floors need special attention. The tendency to specify floors

requiring high polishes and slick surfaces must be resisted, since such floors are dangerous, particularly to old people. Modern plastic tile floors are available that are easy to maintain, require only water for cleansing, do not have to be waxed or polished, and present a surface that is both easy for the feet and safe. Dictates of budget often lead to the installation of cheaper, less satisfactory floors. In subsequent years maintenance and replacement costs and a larger insurance premium show this to be a shortsighted policy.

Lighting must be adequate in all areas and include fairly bright corridors, safety lights at all exits and stairwells, and night lights in all rooms and corridors. The use of recessed fixtures in hung ceilings in modern construction has added to the ease of maintenance as well as creating attractive interiors. The provision of two-way wall bracketed safety lights over beds rather than extension arms, bed mounted or standing lamps, is safer and should be encouraged. Silent wall switches are a good feature if you can afford them.

AFFORDS GREATER COMFORT

Heating and ventilation are important considerations in planning, and recent developments create the possibility of interior environments that can be extremely comfortable. The engineers tell us that panel heating with the heat coils in the construction slab, in walls or in ceilings creates uniform temperatures throughout the room and reduces maintenance costs. Individual thermostatic controls in rooms, although somewhat expensive to install, will save fuel and give greater comfort.

Air conditioning is useful in certain climates and in certain areas of the hospital. Generally speaking, though, air conditioning throughout the institution is not to be condoned in temperate zones, because repeated exposures to suddenly reduced temperatures and humidities are often more shocking than the heat and high humidity they are designed to overcome. Nevertheless, judicious use of air conditioning, particularly in operating rooms, recovery areas, and special purpose rooms is to be encouraged.

We noted at Montefiore Hospital in New York, where most of the patients were in the chronic disease classification and in the older age group, that mortality increased on days when marked increases in humidity or temperature occurred. Patients in debilitated states do not withstand atmospheric changes well. Some air-conditioned rooms could be used to advantage where a large number of debilitated patients are cared for. Old people undergoing major surgery are subject to postoperative fluid imbalance to a greater degree than are younger patients, except children. Air-conditioned, postoperative recovery rooms, therefore, are to be encouraged, since they will help to maintain the fluid balance of the patient by eliminating relatively high humidities or temperatures.

The installation of piped oxygen and suction systems in the nursing and operating units will save time and personnel, as will modern intercommunication systems in all units of the center. Buzzers, bell and light emergency signals from toilet, bath and shower rooms must be remembered and specified in the plans. Patient-nurse signal and voice intercommunication systems have become popular in recent years. Their usefulness seems to depend on how well the staff and patients are trained. A new radio signaling device for paging doctors and other personnel only recently has become available to replace loudspeaker and light paging systems. Its use in medical centers, hospitals and old age homes will make them quieter and pleasanter to live in.

Old people and sick people are gregarious just like the rest of us. In institutions for the aged or the chronically ill, ambulatory patients tend to congregate in the corridors, even when adequate day rooms and balconies are available. They like to see what is going on, to meet newcomers, to watch the staff, to comment on the passing scene, to be sidewalk superintendents. These facts should be considered in design. It is not uncommon to see a group of patients congregate in wheel chairs and on stretchers in the corridors, although a beautiful day room equipped with radio, television, occupational therapy facilities and books is immediately adjacent.

Such day room facilities are needed in greater abundance than ever in our hospitals and old age homes. But we must make provisions, at the same time, for the patients to feel at home —to help run the place, if only from the side lines. Give them ample corridor expansion areas, balconies and gardens, from which they can see and be a part of the activities around them. Encourage productive and often income producing activities, hobbies and workshops for those who need them for both physical and psychological well-being as well as for rehabilitation. Let our patients feel that by coming into the center, they continue to be desirable and useful individuals. Let the hospital's units reflect these considerations in like measure.

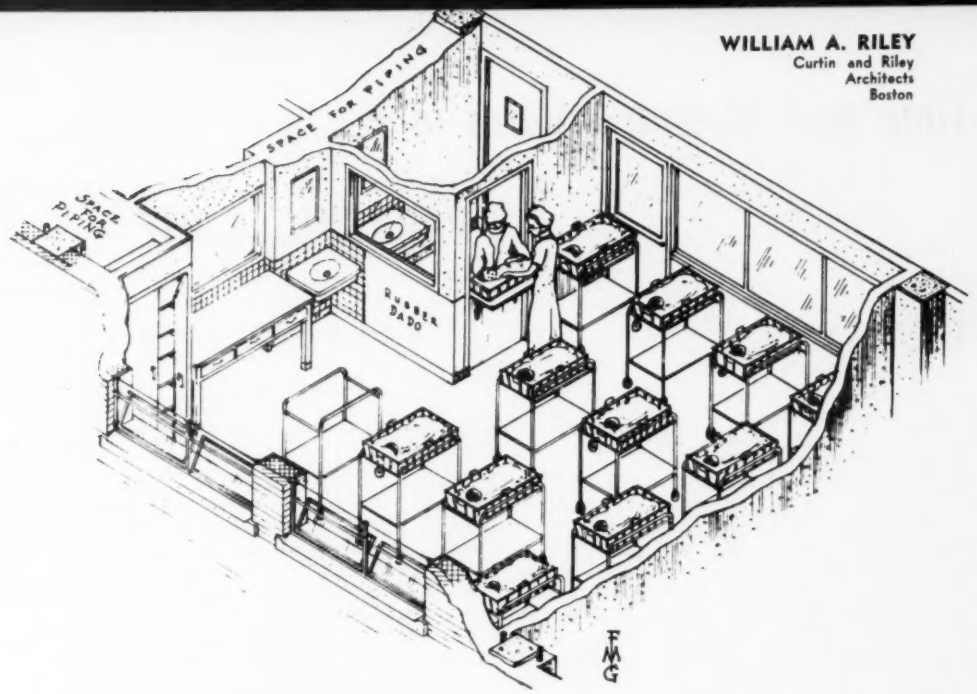
We often forget, in our concern for budgetary requirements, that before entering an institution people required privacy in their daily lives. Yet when we assume responsibility for their health or maintenance we deny privacy when it might be therapeutically useful and psychologically necessary. Large wards, even rooms of two to four beds, do not allow for such privacy. Nevertheless, they are a great improvement over the old open ward. The smaller the number of beds per room and the greater the flexibility possible in meeting the fluctuating needs of patients of opposite sexes, different ages, degrees of illness and debility, the better the individual care. Separate toilets for every room are expensive, but today they are being included in most plans and are no longer considered luxuries. Sinks should be in every room for they greatly reduce the work of attendants and nurses.

PLAN SOME APARTMENTS

In planning facilities for the aged, we should keep in mind that in the old age home there may well be many able bodied people, married couples and persons desiring or capable of doing their own light housekeeping. Small apartments and cottages are needed for some and should be provided.

The proximity of the center to the athletic and recreational facilities of the community is important. It enables the patients to be spectators and to continue interest in activities from which they otherwise would be excluded. Our patients and resident aged should be included in the ceremonial and holiday activities of the community, which should take place near or on these grounds. People will fear old age and illness less, as they live with it and near it more. Let us not hide our aged or our ill. Let us be proud of the increased span of years allotted to us and plan intelligently, resourcefully and completely to make the best of them.

WILLIAM A. RILEY
Curtin and Riley
Architects
Boston



New Ideas for Nurseries

THE nursery and anteroom arrangement shown is the result of years of study during hospital construction. The primary objective was to design a layout which would satisfy stringent state laws and still give a maximum of functional service.

The nursery is a general nursery—limited to 12 bassinets, with a minimum of 24 square feet per bassinet—with the usual 2 feet between bassinets, and the 3 foot aisles. The nursery is laid out in such a way that each bassinet can be seen clearly from corridor viewing windows, also allowing work space for nurse, with table, linen storage, and lavatory.

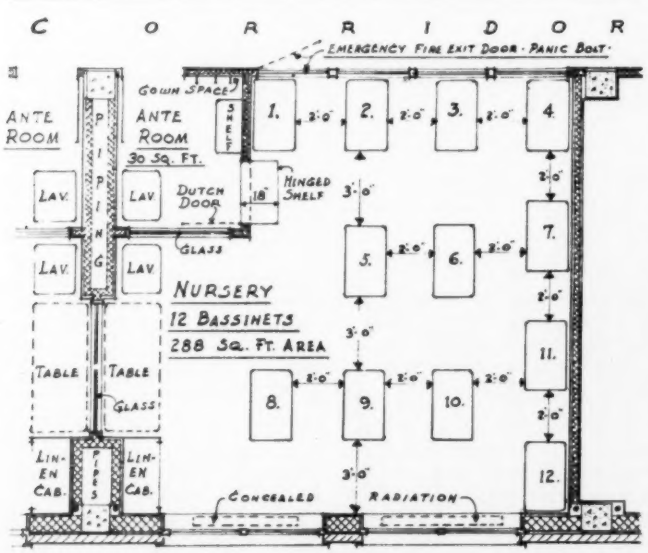
The anteroom, used as entrance to nursery and also by the doctor, provides lavatory, gown space, counter shelf for instrument bag, and examining shelf, with a drop leaf, on the Dutch door.

An emergency exit door direct from nursery to corridor is shown, and numerous glazed sash give over-all supervision.

Two large windows furnish ample outside light and ventilation, with concealed risers for radiation under windows.

The nursery has the usual air changes by mechanical ventilation.

The layout shown, which varies considerably from conventional layouts, and incorporates many new ideas which have proved their worth, was first used at St. Elizabeth Hospital, Brighton, Mass., and later in all our recent hospitals, such as Sceva Speare, Plymouth, N.H., St. Luke's, New Bedford, Mass., and St. Vincent, Worcester, Mass., and has the approval and recommendation of the Massachusetts State Department of Public Health.



Time and Motion Studies in the OPERATING SUITE

OBSERVATIONS OF TYPICAL PROBLEMS

FREDERICK E. MARKUS

Markus & Nocka, Industrial Designers and Engineers, Boston

IN THE process of making specific studies in the operating suite, many incidents are observed which might not appear to bear on the matter under study but are nevertheless of sufficient interest to warrant recording for further evaluation. Mishaps caused by bottlenecks in traffic fall into this classification.

For example, an aisle between equipment in a certain storeroom measures roughly 22 inches. A nurse was sent to the storeroom to obtain a piece of equipment which measured 24 inches in width. After an ineffectual struggle, an orderly came to assist her. It was necessary to do considerable rearranging of other equipment to remove this one piece. During this delay, the surgical team was completely held up and nerves became increasingly edgy.

There was a similar case where a nurse was replenishing solutions in the warming cabinet from a supply truck. The truck became wedged between a projecting sterilizer and several conflicting doors which made it almost impossible to transfer the solutions. There was first the struggle to get the truck into position, then the transfer of the solutions from a cramped and restricted position, and still a third struggle to release the truck. This is presumably a daily routine and was repeated in three locations. The marring of doors and walls gives further evidence of the problem.

Of equal interest are incidents which reflect considerable waste motion and loss of time owing in some cases to lack of proper facilities but, more often, to facilities which are a fixed part of the structure but deficient functionally. A few of these incidents have been illustrated on the opposite page.

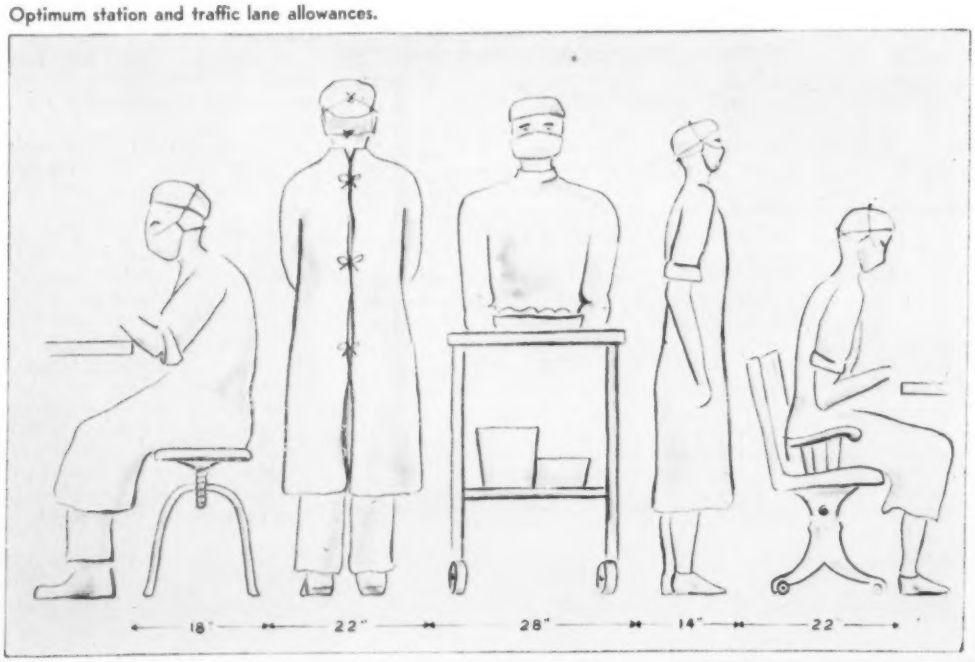
Of particular interest is the need in the operating room for a place to write or perform occasional chores, such as the weighing of sponges and the recording of the fluid absorbed. In one case, the recording sheets were tacked with adhesive tape onto the wall. This meant getting up from hands and knees at weighing to a standing position for each recording.

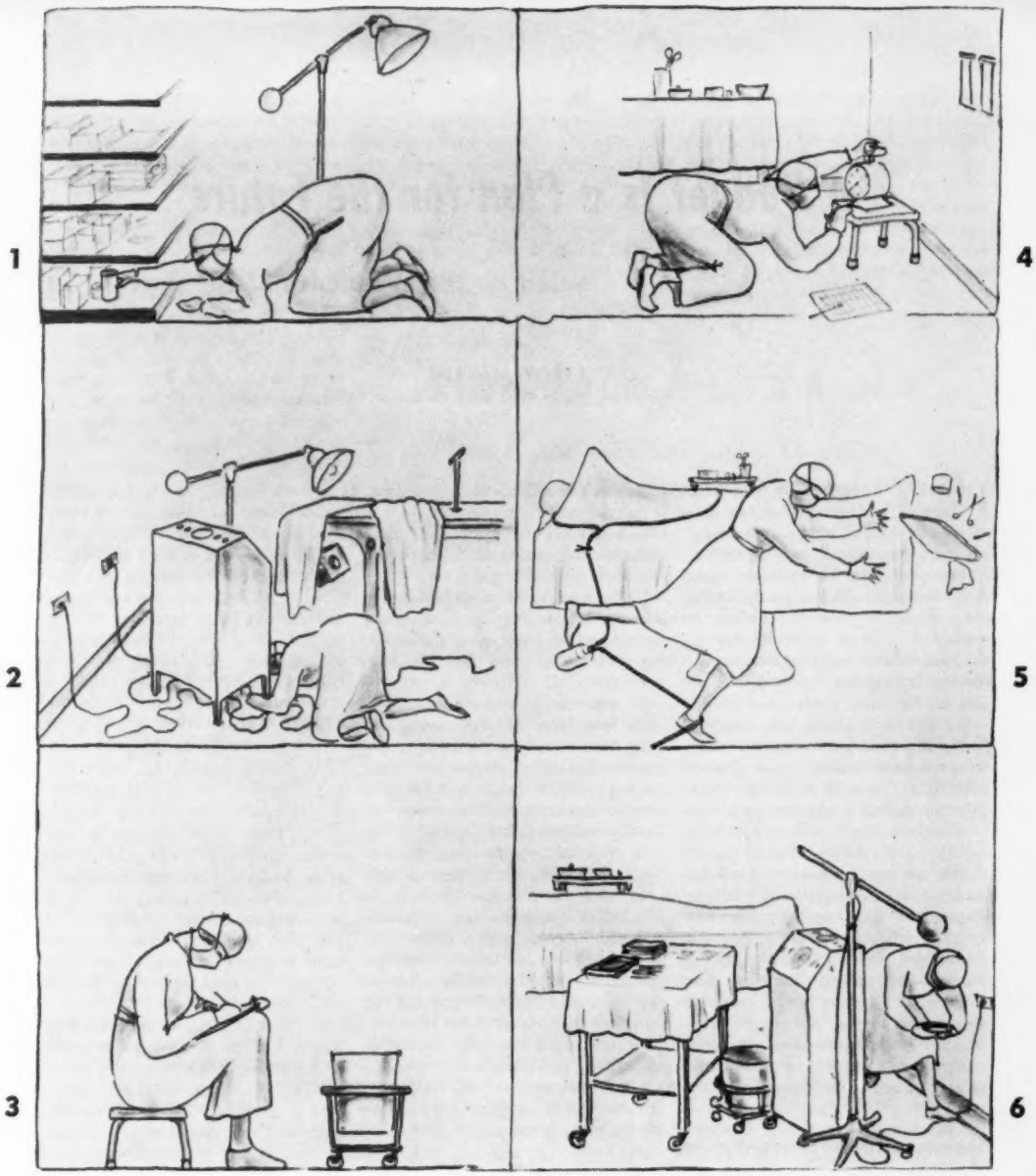
Better to illustrate the need for a writing surface of some kind, three examples of improvisations are of interest. In one operating room, a loose board was placed on a high radiator. It was used in a standing position but was too high to be convenient; it was rather unstable, and furthermore was in a dark corner. I was assured by the nurses, however, that there was considerable need for the board.

At another hospital, the same problem was met by utilizing one of the shelves of the supply cabinet. For

This is the first of a series of articles on time and motion studies in the operating suite.

Optimum station and traffic lane allowances.





1. Circulating nurse hunting for equipment. Cupboards are too deep and low. 2. Circulating nurse unscrambling cords from between legs of equipment preparatory to room cleaning. 3. Student nurse doing paper work on her knee. A small built-in desk or counter is needed for this. 4. Circulating nurse weighing sponges during a cardiac operation; weight is then recorded on charts taped to the wall with adhesive tape. 5. Disaster follows as supervisor catches foot on suction tubing. 6. Supervising nurse makes her exit from her station by the only possible route.

this, the nurse sat but there was no knee space and the other shelves interfered greatly. At best, this arrangement was a makeshift.

The best solution noted was a homemade pedestal type of wooden stand with a sloping top plus a stop on the lower edge to prevent paper or notebooks from falling off. This stand could be placed wherever convenient and was at standing height.

The illustrations show but a few incidents noted and recorded during operational procedures. Primarily, they show a lack of basic functional planning. To correct these conditions after they have become a fixed part of a building is virtually prohibitive.

A Budget Is a Plan for the Future

based on the experience of the past

T. LEROY MARTIN
Professor of Accounting, Northwestern University School of Commerce

PRIVATE fortunes as a source of hospital endowment are fast disappearing, and this condition is changing the approach to hospital financing. A few years ago, for example, little thought was given to the provision for replacing a hospital plant when it reached a stage of nonusefulness. It was assumed that funds would be forthcoming from public spirited individuals at that time, as they had in the past. Now, wide-awake administrators are giving consideration to the problem of depreciation and future replacement costs, as well as to the more pressing current budgetary problems.

A budget may be defined briefly as a plan for the future financial operation of an institution which has been made after careful study of the past transactions and the economic and social trends in the institution, the community, and the nation. Just as a ship cannot navigate safely by referring only to a chart of the course it already has taken, a hospital or a business organization cannot proceed safely by referring only to the financial records of what has happened in the past.

PROVIDES ESTIMATE OF FUNDS

A budget is desirable because it provides a careful estimate of funds required for capital outlay for equipment and major repairs as well as for working capital. It indicates that available funds may be invested temporarily to produce income; and it may indicate the immediate need of working capital and permit the problem to be attacked promptly.

A budget also estimates collections according to a reasonable plan of expectation. Comparison of collections with budget estimates will indicate a trend before losses occur or a slow collection procedure becomes standard. It estimates the time when certain disbursements can be made and eliminates the uncertainty of making commitments for the future.

If loans are to be resorted to temporarily, it provides a plan of repayment which is essential to the securing of credit from any lending institution.

It forecasts bed demands, based upon knowledge of past experience, the expansion of the community, the growth of plans of hospital insurance, the expected change in general economic conditions, and so forth. It also fixes responsibility for each function of administration and provides a yardstick for measuring achievement.

In short, the budget provides a forecast of problems that will arise and permits consideration of them in advance rather than relying upon opportunistic decisions at the moment the financial difficulty is at hand. In other words, it *avoids* rather than *corrects* undesirable financial trends or conditions. A budget will greatly assist the administrator who finds himself continually stepping from one financial crisis into another.

In budget preparation, intelligent estimating replaces haphazard guessing. In the process of setting up a budget, each department head must analyze the available data concerning past operations and expected future requirements. This process forces the individual to become cost conscious as well as efficiency conscious. The soundness of judgment and completeness of analysis in trying to foresee the future will determine how near the budget comes to actual costs and income.

The budget becomes doubly important in changing circumstances. Such circumstances are illustrated by changing economic conditions and by many local conditions. Local changes that will affect the operation of an individual hospital are the opening of a hospital in an adjoining community, the opening or closing of a local factory, gradual increase or decrease in local employment, and increases in use of health or hospital insurance plans.

BUDGET PREPARATION

The basic steps in the preparation of a budget include the following: (1) estimating service to be provided; (2) preparing the income budget using current rates to establish estimated revenue; (3) setting up the expense budget, department by department, which will represent the cost of providing the service estimated to be provided, and (4) bringing the income and expense budget together in the same form as used in the income and expense statement.

Preparation of a summary month by month for two or three years in the past, showing number of patients and number of patient days, by nursing unit if possible, is one of the detailed steps in the preparation of a budget.

Another step includes listing all of the inside and outside factors that will influence hospital population. Inside factors include: bed capacity; service facilities; administrative policies, and capacity of staff. Outside factors are: new industries; withdrawal of industries; other hospitals, and outside agencies.

Estimating patient days month by month after considering similar data for the past two or three years and the changes likely to be produced by inside and outside factors referred to is a step in preparing the income budget.

Also to be determined is the expected patient day income for routine service, based upon patient day income realized in the past, giving effect to expected changes in rates. Deducting free service, bad accounts, and losses on agency patients, as well as estimating nonoperating revenue based upon past experience and considering new sources are other steps.

Preparation of the expense budget by combining all departmental expense budgets for salaries, wages and supplies must be included. These must consider present staff, increases or decreases in staff required to handle budgeted services, and expected general increases in rates or merit increases. Use of all supplies must be budgeted, with consideration given to volume as well as to prices.

Assembling the budget and arriving at net income or deficit, plus considering what changes can or must be made to have a satisfactory financial plan are important. Some of the matters for consideration are: (1) changes in rates; (2) elimination of certain programs, and (3) reduction in departmental costs.

The preceding budget will disclose surplus earnings or deficits, but, for purposes of financial control, the incomes and expenses must be converted to a cash budget, that is, a statement of estimated cash receipts and disbursements.

CASH BUDGET

The cash budget should be prepared as follows:

1. By analysis of past performance in regard to collections, prepare a percentage schedule showing the per cent of the average monthly billings collected in the month billed, the following month, and each succeeding month, until collected in full.

2. Apply these collection percentages to estimated monthly income from patients after deducting estimated bad accounts and free service. For example, this collection budget will show January income from services spread over January, February, March, April, and so forth, in such amounts as the percentages indicate may be expected to be collected in each month.

3. Estimate the cash to be received monthly from nonoperating revenue.

4. Total the monthly columns, which will indicate the cash estimated to be received.

5. Prepare the disbursements budget by summarizing pay rolls in the periods in which they will be paid and deferring disbursements for other supplies and services according to the usual credit terms.

6. Assemble receipts and disbursements by months and compute cash balances or deficiencies. If there are deficiencies at certain points in the year, financing can be provided for in advance of an emergency.

At the end of each month statements of income and expense should be prepared, parallel columns being used to show actual and budgeted income and expenses and actual increases or decreases in comparison with budget figures. Current information should be employed in the preparation of revised budgets at periodic intervals.

Every Hospital Needs a Hostess

She would earn her salary by easing the patient's adjustment to the hospital

IN MANY agencies where interviewing of people is a necessary part of their program, care is taken to see that the person to be interviewed is made to feel at ease in the situation. In many large hospitals, little or no attention is given to the ambulatory patient who comes in for the first time. This patient, whether he is coming in for examination, laboratory work, x-ray tests, or pending surgery, is submitted to a cold efficient routine upon admission. There is no one to greet him as he opens the lobby door, no one to get his bag or coat as is customary in the better hotels. A sign, placed on the counter, may read "Information" or "Admission." The patient stands at this counter and makes himself known as Dr. X's patient. It makes no difference that he is on crutches or that he is feeling weak; unless he mentions it, no chair is offered or suggestions made that perhaps he would like to rest awhile. The admission clerk, in an efficient manner, begins the usual flow of questions—name, age, occupation, address, next of kin.

I observed a number of patients coming into a couple of the larger hospitals in one of our cities in the Middle West and it was the same general routine. Every patient coming in is usually referred by his attending physician and all the foregoing information is on file in his office. It would be a small matter to relay this to the hospital, either by telephone when making the appointment or by a "letter of introduction" by the physician's secretary, given to the patient to take with him to the hospital.

If this is impractical then why not provide a room in which the patient may be seated and allowed to give the information required in privacy. I have rebelled myself at having to give my age and other intimate details to the admitting clerk within earshot of someone standing next in line and the rest of the personnel seated behind the "counter," plus others in the lobby. If you have ever had to go to the hospital for surgery, you will know the anxiety and fears that arise when you finally get to "admissions" and what it would mean to have some person, other than members of the family who are also anxious, to greet you, help you to relax a little, and listen while you express some of the doubts and fears that are troubling you. A hostess trained in human relations would be a valuable asset in any hospital, especially in "admissions."

She would also function as the person who will help when the patient is ready to leave. Too often the patient is directed to the cashier's desk where he stands and pays his bill over the counter as one would pay his bill in the chain store grocery. The private room where he can sit down, take care of his bill, and be given a pleasant smile and handshake as he leaves the hospital would amply repay the hospital in the feeling of good will which would be developed from this type of service. A warm greeting by an understanding person who would treat the patient as one would treat a guest entering his home would be a step forward in the adjustment of the patient to his stay in the hospital.—EMMA HARLING, R.N., *mental hygiene nursing consultant, Colorado State Health Department, Denver.*

They Made Hospital History

BARON LARREY

OTHO F. BALL, M.D.
President, The Modern Hospital Publishing Company, Inc.

"From the earliest records of history the physician has been regarded as one of the most important attachés of the army. Here as everywhere else, his errand is one of blessing and mercy; laboring to mitigate and repair, by the beneficent resources of his skill, the multiform accidents which are incident to such a calling. Without a systematic enforcement of the sanitary measures so well established by his science, the best appointed army must melt away from disease, which always proves the most serious enemy encountered by the soldier. War, therefore, has in some measure been the nursery of medical science and contributed largely to establish many of her principles on the immutable basis of truth, and to confer on many names an immortality as lasting as time." D. H. AGNEW.

THE foregoing quotation concerns Baron Larrey, the "first and greatest military surgeon." As surgeon general of the French army, Larrey followed Napoleon in all of his campaigns from 1792 to the battle of Waterloo in 1815, caring for the injured, fighting epidemics, setting up hospitals and an ambulance service before a coming battle, and amputating limbs on the battlefield, utterly regardless of his own safety and health. He made no distinction between private and general, between friend and foe. Often the enemy deliberately left behind its wounded, knowing Larrey would soon be along to succor them.

Jean Dominique Larrey was born in July 1766 in Beaudeau, a little village in southern France at the foot of the Pyrenees. He received his early instruction from the village curate, Abbé de Grasset, and sang in the church choir. When he lost his father at 13, he joined his uncle, Alexis Larrey in Toulon, surgeon-major and professor at the hospital of La Grave and corresponding associate of the Royal Academy of Surgery in Paris.

After six years of study in the schools of medicine and surgery at Toulouse, Larrey went to Paris, when he was 21. In a competitive examination held a few days later for assistant surgeons of the Royal Navy, his qualifications brought him an appointment as surgeon-major. In May 1787 he boarded the *Vigilante,* charged with protecting the cod fisheries on the shores of Newfoundland. While awaiting orders, he gave lectures on anatomy and surgery and sought what knowledge he could regarding navigation by visiting with galley slaves and by haunting arsenals and shipyards.

Among the imprisoned galley slaves was Louis Bourbon who, incarcerated in various dungeons for 33 years could see only at night and who in playing the flute, his only diversion, had worn a depression in the ribs where he rested the instrument.

The storm-battered sloop reached Newfoundland after 54 days; all had kept well except two men were swept overboard and lost. Back in Paris two years later (1789), Larrey cared for the early victims of the Revolution at Hôtel Dieu. Being refused appointment as an intern at the Hôtel des Invalides, he left for Brest but soon afterward was recalled and made second surgeon at the hospital.

All through his busy life Larrey was tirelessly devising better surgical methods, writing of the diseases he treated, and teaching anatomy and surgery. While senior assistant surgeon at the hospital of Metz (1792) he invented a lancet pointed needle with a groove leading from the eye into which the suture sank and for this was awarded a gold medal, 100 livres in value, by the Royal Academy of Surgery.

OPENED SCHOOL AT STRASBOURG

Appointed surgeon-major of the army of the Rhine in 1792, he at once opened a school at Strasbourg where he taught military surgery. It was during this campaign that Larrey became distressed by the ambulance service of the army. Narrow, heavy caissons loaded with instruments and dressings stood three miles back of the lines. Eight surgeons and an equal number of assistants rode the horses, sat on the supply chests or balanced themselves on the rounded tops. The wounded were picked up when the battle was ended, often after lying on the battlefield for from 24 to 36 hours. Larrey devised light two-wheeled and four-wheeled carriages with springs, which contained mattresses and were drawn by two or four horses. These "flying ambulances" with their swift passage over the rough battleground were first demonstrated in 1792 at Königsberg. Often amputations were performed within five minutes of the injury and the wounded were transported immediately to hospitals already set up some distance away. His new idea accepted, Larrey superintended the construction of the *ambulances volantes* for all the armies of the republic. During this short interim of peace he married the daughter of Laville-Leroux, minister of finance under Louis XVI.

The story of Larrey's life from that time, largely gleaned from his memoirs of Napoleon's campaigns, is the history of the French wars, an absorbing tale of victories and defeats and the terrific slaughter of men. Little can be related here of those long years of war. In 1794 at the age of 28 Larrey was appointed surgeon-in-chief of the army going to Corsica. After his return he served as inspector of the military hospital at Toulon and lectured in the school. He was then elected a professor at the military school of Val-de-Grace in Paris.

JEAN DOMINIQUE LARREY
(1776-1840)

ORGANIZED AMBULANCE SERVICE

Larrey was sent to Italy in 1797 to organize the ambulance service there. His improved *cadre de l'ambulance volante* had an attachment of 340 officers and soldiers. Each division had 12 light carriages and four heavy ones, with either two or four wheels. At Milan Larrey established a school of surgery and then joined the advance guard at Bernadotte, inspected the hospitals, examined medical officers, and successfully fought the progress of an epidemic. That was his program everywhere he went. Called from one area where he established the ambulance and hospital service, he hurried to another region to prepare for another terrible battle. Always between battles or between campaigns, while he directed the surgical service, he gave lectures to the surgeons and military men, inspected the military hospitals, or wrote treatises on surgical diseases encountered in his work. Sometimes himself prostrated by sickness or utter exhaustion, he would rest two or three days, then hurry on to further duties.

While in Venice in 1797 he studied a disease that was destroying the cattle of the area and the success of his suggested treatment brought a gracious letter from the government of Udine, expressing regret that no fitting award except gratitude could be offered.

In May 1798 Larrey was made surgeon-in-chief of an army of 30,000 men then departing under General Bonaparte for Egypt and Syria. He began at once to collect material, organize a medical staff, and assemble his ambulances. His appeal drew surgeons from the medical schools of Toulouse and Montpellier and others, until he had mustered 800 well qualified surgeons. Ten thousand soldiers marched on Alexandria. Three divisions of ambulances had been provided, one for each wing and one for the center, Larrey accompanying the center one to be near Bonaparte. The wounded were taken to the convent of Capuchin friars. There General Figuières was successfully treated for a serious wound and in gratitude he presented a valuable Damascus sword to Bonaparte who in turn gave it to Larrey, first engraving on the sword "Aboukir and Larrey." This cherished gift Larrey lost at the battle of Waterloo.

At Cairo (1798) Larrey found splendid hospitals ready for conversion into military hospitals and there he opened a school of practical surgery. While in that city he recognized what a major problem syphilis had become in the army and established a hospital for prostitutes and afflicted soldiers. As he went along he provided military hospitals at Suez, Chefarmer, Mount Carmel, Caiffe and Nazareth. Whenever Larrey left a hospital to follow his commander or to execute a mission, he left behind a corps of surgeons to care for the wounded. When crossing the desert of Egypt, Bonaparte is said to have placed his horse and those of his suite at the disposal of Larrey and his ambulances and marched on foot for several days over the hot sands. The suffering from the heat, lack of water and the hot wind of the khamsin was intense.

During the blockade of Alexandria by the English in March 1801, the hospitals were filled to capacity with 1900 wounded, yet two months later 1000 were back in the ranks and 600 others were recovering. During the following month a severe ophthalmia attacked 3000 men and 3500 men were admitted to the hospital with scurvy; 262 of the latter died. Larrey worked day and night without sleep and food and when provisions ran low, he had the horses killed to prepare soup for his patients. In two months he lost 14 surgeons, 11 apothecaries, three physicians and all his nurses. General Berthier in a letter of commendation notified Larrey that his wife was well and had been given 1500 francs as a testimonial of national gratitude for the great work he was doing, including dressing the wounds of his brave associates under enemy fire and at the entrance of the breaches.

On his return to Paris, Napoleon made him chief surgeon to the consular guards (1802). Busy writing his work, "Surgical Account of the Army of the East," Larrey also began a public course of lectures on military surgery and, after preparing a thesis on amputation (1803), received the degree of doctor of surgery at the medical school, the first to have that honor. After Napoleon became emperor of France, the Order of the Legion of Honour was established and Larrey in July 1804 had that honor conferred upon him at the Hôtel des Invalides, the emperor saying: "C'est une récompense bien méritée." When in 1808 Napoleon was crowned king of Italy, Larrey received the insignia of chevalier of the Order of the Iron Crown. That same year he received at Jena the degree of doctor of physic, and the Academy of Sciences in Paris made him a corresponding associate.

RECEIVED TITLE OF BARON

During the campaign in Austria after the battle of Wagram and while negotiations for peace were pending, Larrey erected an amphitheater in Vienna where he gave courses in theoretic and clinical surgery and in adjoining rooms directed dissections. Surgeons of the French army and of Vienna both attended. Upon delivery of his report on the operations of this campaign, the emperor conferred on him the title of baron and an annual pension of 5000 francs.

A close friendship always existed between the emperor and the surgeon Larrey. Larrey was utterly devoted to his country and to his general and Napoleon repeatedly sounded the praises of his surgeon-in-chief. During the second campaign in Austria when the army was cut off from its supplies, Larrey again ordered soup made of horse meat to feed his patients. The French generals protested loudly; it was a wanton violation of epicurean

and human rules. When they complained to Napoleon he sent for Larrey and demanded sternly: "Have you on your own responsibility disposed of the horses of officers in order to give soup to your wounded?" Larrey stoutly answered: "Yes, your majesty." It was soon after that he was elevated to the baronage.

For two years (1810-11) Baron Larrey directed the hospital of the imperial guard in Paris. He then became surgeon-in-chief of the grand army, whose mission was to drive the Russians out of Europe. Larrey, now 46 years old, had served as military surgeon for 25 years. His terrible experiences in Russia fill many pages of his memoirs. Four hundred thousand men marched against the semi-barbarians. Few of them came back. At the battle of Moskva Larrey performed 200 amputations in twenty-four hours. There were no beds, no blankets; the only food consisted of horse flesh, cabbage stalks and a few potatoes. There were few surgical supplies and soldiers lay on the damp ground. Larrey worked incessantly, tenderly caring for the wounded.

PRISONERS BURN THE CITY

When the French reached Moscow they were amazed at its grandeur, its great churches with their silvered and gilded cupolas and spires, and the immense citadel, the Kremlin. The soldiers slept in luxury and dined sumptuously, while Larrey visited the fine hospitals, unaware that the retreating Russians had opened the prisons and ordered the robbers and murderers to burn the city. The scene became one of "sublime horror." After the third day only the Kremlin, the churches and a few stone houses remained. All supplies were gone. It was a barren conquest.

Continual attacks of the circling Cossacks decimated the ranks of the French, yet Larrey and his staff worked valiantly. Napoleon who had brought 103,000 combatants to Russia had 90,000 fighting soldiers and 20,000 sick and wounded in Moscow, yet because of splendid care he departed with 100,000 able-bodied men. The sick who could not be carried along were put into a foundling hospital with medical officers to care for them. A month later the troops had fought their way to ruined Smolensk, a city almost without food and reeking of unburied corpses. Only 36,000 combatants remained in Napoleon's army.

As the French army retreated in Russia, the cold was intense, many who marched fell asleep and died where they fell; those who rode contracted gangrene in their half-frozen legs. Starving men caught riderless horses and cut them to pieces for food. Larrey carried wounded men on his back and shared the precious water in his canteen. At Orsha Napoleon led only 12,000 men. At Bérésina Larrey crossed the bridge with the imperial guard only to find his surgical supplies has been left on the other bank. Recrossing the stream, he was met by a wild, pushing crowd and would have been crushed, except that the soldiers recognizing him passed him through their midst to safety crying: "Let us save him who saved us."

The men retreated through snow and biting cold, so disfigured by their suffering and by icicles clinging to their eyelashes and beards that they scarcely recognized one another. All but 350 of 12,000 men in the twelfth division perished of the great cold. Larrey arrived at Vilna exhausted but the Grey Sisters of Charity gave him tender care. Only 3000 remained of the army of 400,000. The next day he established a hospital for the ill, but the enemy pressed them on. The badly wounded remained in the hospital and in homes, and Larrey left letters asking the Russian force to care for them, but as soon as the French had left the inhabitants threw them naked out-of-doors.

Larrey entered Gumbinen with the remnants of the imperial guard and for a time they enjoyed luxuries. Exhausted, Larrey reached Königsberg late in December but the next day made his rounds of the hospitals. There he came down with typhus fever but finally recovered. The French fought their way back through Saxony. Many young soldiers then in the ranks had suffered loss of their fingers. Napoleon was indignant at the insinuation that they had mutilated themselves and appointed Larrey head of a medical jury to investigate.

Larrey, who bitterly resented the calumny against the soldiers, showed up with a thorough study of all the wounded men and proved that many of these untrained soldiers had held their guns improperly and wounded the men in front of them. That evening Larrey received from the grateful emperor his picture set in diamonds, 6000 francs in gold, and a state pension of 3000 francs.

"From the banks of the Nile to those of the Danube, from the camps of Boulogne to that of Austerlitz, from Leipzig to Waterloo, Larrey was present in all the most bloody battles of modern times. However, Larrey as a military surgeon sought all these dangers of war for no other purpose than to mitigate its evils."

Following Napoleon's abdication Larrey remained with his emperor at Fontainebleau until he departed for Elba. Larrey begged to accompany him on his exile but Napoleon replied: "Larrey, you belong to the army, you ought to follow it; yet it is with deep regret that I separate myself from you."

When Napoleon returned from Elba, Larrey stood unwaveringly beside him until they separated at Waterloo. Larrey operated on the field at Waterloo, caring for the wounded, all night long. In the retreat his horse was shot under him and Larrey fell unconscious with two saber wounds. Thinking him dead, the enemy went on. Regaining consciousness he remounted his horse, now on its feet, and rode through the cornfields, only to be recaptured.

MISTAKEN FOR NAPOLEON

His clothing resembling that of Napoleon, the enemy thought their prisoner was the emperor. Finding their mistake they prepared to shoot him, but the surgeon-major who advanced with a handkerchief to bind his eyes recognized the almost naked man standing in bare feet, his hands tied behind his back and his head covered with bloody bandages. Larrey was passed on to a distinguished surgeon at Louvain and by permission of the commander was returned to his home in Paris.

With Napoleon banished to St. Helena, Larrey came upon hard times, for his long friendship with the emperor brought its punishment. His pension and every office except that of surgeon to the hospital of the guard were taken from him. His mother had died of grief, believing him killed, and his brother, a surgeon at Nîmes, had also died. So great was his distress that he almost obeyed the prayers of his friends to go to America. The emperor of Russia and Don Pedro made tempting offers for him to take charge of their armies, but he loved France too much. He quietly settled down to writing the fourth volume of his memoirs of the campaigns of

(*Continued on Page* 136)

About People

Administrators


Robert F. Brown

Dr. Robert F. Brown has been appointed director of Doctors Hospital, Seattle, succeeding Dr. K. H. Van Norman, who has retired. Dr. Brown will move to Seattle about August 1. For the past seven years, Dr. Brown has been medical director of St. Luke's Hospital, Chicago. A graduate of the University of Oregon Medical School and the graduate program in hospital administration at Northwestern University, Dr. Brown was assistant superintendent of Stanford University Hospitals, San Francisco, before going to St. Luke's in 1945. He has been a member of the faculty of the Northwestern University program in hospital administration.

Dr. George F. Swanson, present manager of the general medical and surgical Veterans Administration Hospital, Beckley, W. Va., has been named manager of the V.A. Hospital at Philadelphia, which is scheduled for completion in July 1952. Another administrative appointment V.A. announced was that of **Dr. Roland W. Hipsley,** chief of surgery at the V.A. Hospital at Minot, N.D., as manager of the hospital. He succeeds **Dr. John B. McHugh,** who has been transferred to the new V.A. Hospital at Kansas City, Mo., as manager. Four assistant hospital managers also have been named by the Veterans Administration. They are: **James R. Harrison** at Spokane, Wash.; **Raymond E. Ideker** at Dallas, Tex.; **Alonzo L. Gaubert** at Minot, N.D., and **James M. Ritchie** at Salt Lake City, Utah.

George I. Mattix has accepted the post of administrator of Morris Memorial Hospital, Milton, W. Va. A graduate of the program in hospital administration from Northwestern University, he formerly was connected with the Public Health Service, Federal Security Agency, as administrative officer.

C. T. Loftus has assumed his new duties as administrator of Mercy Hospital, Benton Harbor, Mich., succeeding **Richard Hocking.** His former position was as administrator of Rockingham Memorial Hospital, Harrisonburg, Va. Mr. Loftus is a nominee of the American College of Hospital Administrators.

Gerhard A. Krembs has resigned as administrator of the Door County Memorial Hospital at Sturgeon Bay, Wis., to accept the post of administrator of the Ishpeming Hospital, Ishpeming, Mich. A graduate of the course in hospital administration from Columbia University, Mr. Krembs is a nominee of the American College of Hospital Administrators.

Mortimer Zimmerman will assume his new duties July 1 as administrator of the Lewis A. Weiss Memorial Hospital in Chicago, which is still under construction. At present Mr. Zimmerman is personnel administrator at Passavant Memorial Hospital, Chicago.

Donald S. Slade, assistant manager of the Veterans Administration Center at Kecoughtan, Va., has been appointed manager of the V.A. domiciliary at Clinton, Iowa. He succeeds **Frank A. Cleveland,** who retired April 30.

Eugene L. Bailey has been appointed administrator of Gregg Memorial Hospital, Longview, Tex., succeeding **Harry Miller,** who resigned to accept a position with McAllen Municipal Hospital, McAllen, Tex. Mr. Bailey, who has been in hospital administration work for the last 22 years, since 1949 has been associated with the Panola General Hospital at Carthage, Tex., first as a consultant and later as administrator. A member of the Texas Hospital Association and the American Hospital Association, he is president of the East Texas Area Hospital Council. He also was selected to serve on the council on construction and plant operation of the T.H.A. for the coming year.

Earl Benson has resigned as administrator of the Muskogee General Hospital, Muskogee, Okla., to accept the position of administrator of the Medical Center Hospital at Odessa, Tex. First vice president of the board of trustees of the Oklahoma Blue Cross plan and a member of the hospital liaison committee for arbitration of differences between the hospitals and Blue Cross, Mr. Benson has served two terms as president of the Oklahoma State Hospital Association and is a member of the board of directors of that association. He is a trustee of the Mid-West Hospital Association and has served two years as a member of the house of delegates of the American Hospital Association.


W. C. McLin

W. C. McLin has resigned as assistant administrator of Methodist Hospital, Indianapolis, to accept the post of administrator of Mound Park Hospital, St. Petersburg, Fla. Administrative assistant at the University of Iowa Hospitals from 1935 to 1941, Mr. McLin served in the army medical administrative corps from 1941 to 1945. In 1946 he was assistant administrator at Jewish Hospital, Cincinnati. A member of the American Hospital Association and a fellow of the American College of Hospital Administrators, he also is chairman of the committee on insurance rates for the Indiana Hospital Association.

Thomas S. Adams Jr., formerly administrative officer at the Payne-Whitney division of New York Hospital-Cornell Medical Center, New York City, has been appointed assistant superintendent of Yonkers General Hospital, Yonkers, N.Y.

Carlos Smith is now the administrator of Helena City Hospital, Helena, Ark. Mr. Smith studied hospital administration at Northwestern University.

John S. Cherry has assumed his new post as superintendent of City Hospital, Magnolia, Ark. He is the former superintendent of Desha County Hospital, Dumas, Ark., and previous to that he was business manager of the Davis Hospital, Pine Bluff, Ark.

Dr. Bernard L. Allen, formerly manager of the Veterans Administration Hospital at Clarksburg, W. Va., is now manager of the V.A. Hospital at Manchester, N.H.

Joseph Hew has been appointed acting administrator of Bradford Hospital,

(*Continued on Page* 174)

An O.R. Supervisor Can Dream—and Does

GLADYS S. BLIZZARD, R.N.
Chicago

In this section of her series of "ideals" for operating rooms, Mrs. Blizzard offers some revolutionary ideas for the construction of floors and walls. It is her theory that rising blocks set into the floor could be raised to any desired height and used by the operating room staff for either sitting or standing.—Ed.

FLOOR

RECOMMENDATIONS	RESULTS
Grounded.	Lessens danger of explosions.
The floor is tiled with rising blocks (12 by 8 inches) controlled by pressing an indented button in the corner of the block with a finger or the toe of a shoe. Each block can be raised or lowered to the desired height to be used for either sitting or standing.	Eliminates excess furniture. The blocks can be raised, as standing platforms, by the persons scrubbed. This does away with the scurry and shuffle to get enough platforms in place all at the same time. The blocks are always there and ready for use.
These blocks can also be raised and draped and basins set on them for use as splash basins. These blocks are also raised and basins are set on them to be used as discard basins. (See Figure 1.)	Using the blocks raised high and with discard basins set on them, instead of floor pans, lessens the danger of lost sponges under the table and people's feet. It is also more convenient to discard sponges into a high basin and lessens the chance of contamination. It is easier for the circulating nurse to pick up sponges and discarded instruments from a higher level than from the floor.
As the operating table is always in approximately the same position on the floor, the suction and cautery controls come from the floor under the table.	No moving of heavy machinery. No cords across the floor to trip over.

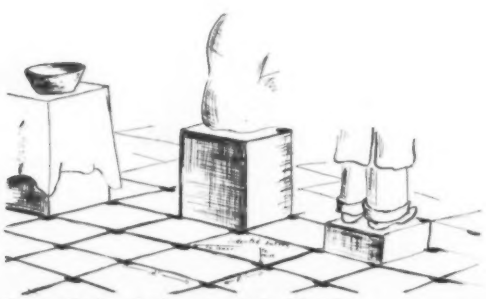


Fig. 1: Blocks raised to any desired height.

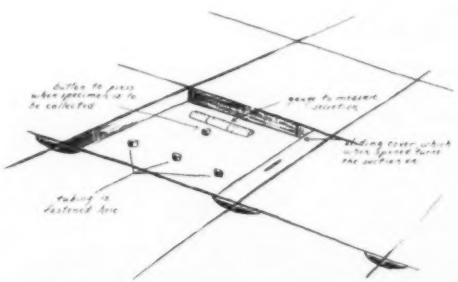


Fig. 2: Controls for suction apparatus.

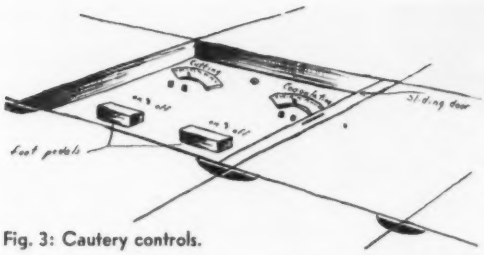


Fig. 3: Cautery controls.

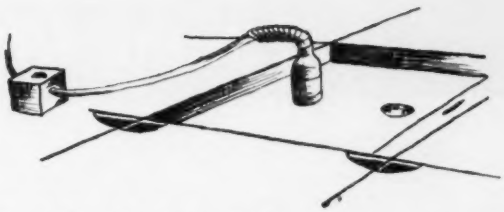


Fig. 4: Extra plugs for headlights.

The suction has an automatic gauge to measure the amount of secretion as it passes through the tubing to the workroom below. If a specimen of the secretion is to be saved a switch is turned on and the specimen is collected on the floor below. If no specimen is desired the secretion flows through to the sewage disposal and is thereby discarded without being handled. (See Figure 2.)

No bottles standing around to collect dust and be in the way.
No handling of contaminated secretion in the operating room.

The cautery controls are also under the operating table set in a block on the floor with a sliding cover for protection when not in use. (See Figure 3.)

Since the operating table is always in approximately the same place, the controls can be easily reached by one of the operating team and worked with his foot.

No cords across the floor.
No machine in the operating room unnecessarily to occupy necessary space.

Extra plugs for headlights and so on come from under the table. They also have sliding covers for protection when not in use. (See Figure 4.)

No cords across the floor.
No need for long extension cords which when added break the grounded effect desired.

WALLS

RECOMMENDATIONS

Everything is built into the walls.
All round corners.
The doors slide into the wall and open and close by close-range electric eyes.
All the doors to the dummies, autoclaves and shelves open by sliding upward and are opened and closed by knee level push buttons.
The sterile water is piped into the operating room from the workroom. It is turned on and off by knee level buttons. (See Figure 5.)

RESULTS

Dust cannot collect.
Cleaning is easier.
Operating rooms can be smaller.
Room space is not wasted.
Easier to clean.
Convenience unequalled by ordinary doors.
Scrubbed persons can open them without waiting for a circulating nurse who may be busy with something else.
No tanks in the operating room.

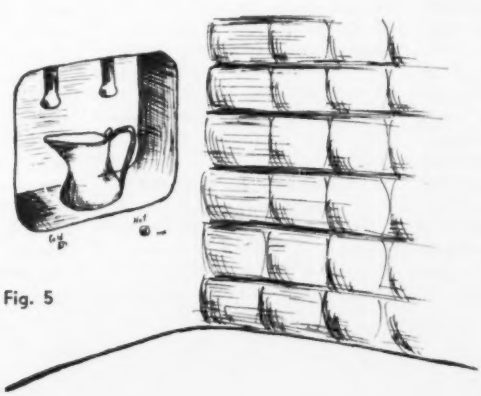


Fig. 5

They Shall Have Music *at little expense*

if the record player is attached to the paging system

BECAUSE few of mankind's activities have a more universal appeal than has music, the study of music in reference to sickness and health is a subject of considerable interest.

Music always has had a prominent and significant part in man's folklore, mores, traditions and living customs. In all races and cultures, music, in some form, has been employed in rite and ritual. It has sometimes been considered medicinal magic and a tool of the witch doctor. Even today those aboriginal cultures that still exist use music in tribal rituals.

IT'S AN OLD CUSTOM

The student of hospital history finds reference to music as a healing art in the Aesculapia of Epidaurus, the great Greek center of healing. Recently an art researcher discovered the reason why a musician was pictured in a mural of nursing mothers in a historic Rome hospital; his playing allegedly stimulated the flow of milk!

In recent times the effect of music on the human organism has aroused considerable interest, and several studies have been made in industry on its influence on production. A few medical researchers have made significant and revealing studies into music therapy.

Researchers have demonstrated actual physiological reactions to music. Muscular activity, respiratory rate, blood pressure, pulse rate, internal endocrine and digestive secretions, encephalographic changes and metabolism have all been shown to be affected by music. Not so easy to measure is the influence music has on mood and emotional change. Everyone agrees that music can be used skillfully to set a desired mood. Motion pictures exploit this idea fully.

In introducing music into the Charles S. Wilson Memorial Hospital at Johnson City, N. Y., we did not seek to exercise a particular therapeutic effect. We reasoned that music is pleasant and adds something to an otherwise regimented atmosphere. With minor exceptions we have found it to be a successful project.

Music has been distributed throughout our hospital plant for several years. Up until two years ago, it was purchased and piped in from a recorded music company; it was played approximately five hours a day, from 11 to 1 o'clock and from 4 to 6:30. However, it became evident that this wired music was not flexible enough in programming and quality to satisfy the hospital's requirements. A subscriber to the service had no choice of selections. Also, plant expansion and a necessary extension of the audible paging system increased the price of the music service considerably.

Consequently, it was decided to discontinue the wired music system and to originate the music on the hospital's premises. The record library, which required considerable study concerning the proper selection of records, was a major part of the project.

CHARLES A. TURNER
Assistant Administrator
Charles S. Wilson Memorial Hospital
Johnson City, N. Y.

EQUIPMENT

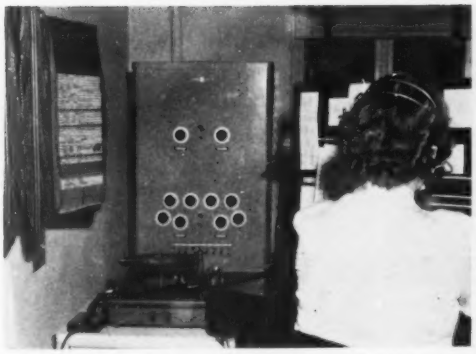
An attractive aspect of the program is the simplicity and low cost of the necessary equipment. Any hospital that has an audible paging system should be able to attach a record player to it. The hospital's electrician or any competent radioman can make the installation.

The player itself can be any good quality, three-speed record changer. The magnetic or variable reluctance type of pickup is recommended because of its higher fidelity response. The pickup definitely should have a diamond stylus, not only for truer reproduction of the music but to decrease record wear and to eliminate frequent changing of the needle. The diamond will play at least 2000 sides, while a sapphire or other semi-precious point is good for only 200 plays.

MUSIC CAN BE DIRECTED

In the usual system, paging can be done right along with and over the music, with no interruption. If the paging system has a zoning arrangement, the music can be directed to particular parts of the plant to the exclusion of others. In our installation, music can be sent to the psychiatric division exclusively or to the whole plant. The idea here, of course, is that psychiatry at times may need particular programming or music that would not be appropriate for other parts of the hospital. This arrangement also can be applied to the laundry, central supply, or other production areas.

A monitoring speaker should be installed near the switchboard so that the telephone operator can hear the music and correct the occasional stuck



The player can be any three-speed record changer of good quality, with magnetic or variable reluctance type of pickup. The pickup should have a diamond stylus, which will play at least 2000 sides.

The operator has a wide range of records from which to choose. A stack of eight 10 inch LP records, played on both sides, or eight 12 inch records played on one side, will run for two and a half hours.

record. However, the volume level of this speaker should be kept low so as not to interfere with paging.

TYPICAL OPERATION

As we said, music is played approximately five hours a day. A stack of eight 10 inch LP records, played on both sides, will run the two and a half hours permitted for the playing period. On the 12 inch records, eight will play the necessary time on one side only. Experimentation soon will reveal the best way to use the records.

The record player will play the stack of records with little further attention from the operator beyond starting the equipment and turning over the stack of records. Occasional maintenance adjustments may have to be made. The operator should be instructed to keep the stylus free from dirt and lint and also to use only the 33⅓ r.p.m. speed. Some disturbing effects can be produced if either of the two higher speeds is used.

THE RECORD LIBRARY

Finding appropriate records to play in the hospital called for considerable initial study. Each record should be listened to before purchase to make sure that the music is suitably arranged. Because an LP record must contain several selections per side, this *pot pourri* of music may contain one or two objectionable selections. In this way, many otherwise acceptable records must be eliminated. Records should not be bought on the basis of selections, but rather on whether the arrangement is satisfactory. Even the most calm and easy going of songs can be given a brassy or otherwise vigorous setting, which can be quite irritating to many persons. The records played are quiet arrangements of standard popular selections and light classics. At present, there is a total of 143 LP recordings, including 121 ten-inch and 22 twelve-inch records. This adds up to 1240 different selections.

The LP records cost approximately $3 list each, but the hospital buyer should receive at least a 10 per cent discount. If preferred, the records can be purchased from discount houses for 30 per cent off list price. The latter course could be specially used if the buyer knows in advance the records he wants, orders them by number, and places a fairly large order. If the records prove faulty, they can be returned, although modern manufacturing methods rather preclude a defective record's getting to the retailer.

Vocal recordings, in general, should not be used except for holiday or Sunday religious music. Vocal music is obtrusive, which is not the desired effect.

No effort is made to program the music beyond starting each period with a subdued selection so that the music is not suddenly thrust upon the hospital atmosphere. Records are arranged in the library so that they are not repeated until all have been played.

Special music may be obtained for Sundays, and this has received favorable comment from many people, both patients and staff.

In general, the reaction to the music program has been favorable. Not too much of the music actually gets to the bedside because the speakers are all in the halls or lobbies. However, the music is there, even though it is not too noticeable, and patients have remarked on how pleasant it is. Also, patients in the clinics and service departments find the music diverting and relaxing. There has been an occasional patient complaint, but these have been quite infrequent and, in each instance, the reaction was that the particular individual thought music out of place around sick people.

IT'S A SUCCESS

We have not made a really serious study of the reaction to the music program, judging its approval and success from a positive point of view only. We have frequent requests for various selections and types of music from both patients and staff.

Doctors, nurses, and other employes also have generally expressed a liking for the music. It is especially well received in the dining rooms and work areas.

We wonder, on occasion, just how much the music is listened to, but this feeling is dispelled when we get a stuck record; the telephone operator immediately receives many reminders. Or, sometimes the operator (possibly a new one) may play the records at the wrong speed and the result is quickly reported to the switchboard. We will never forget the occasion when the last record on a Sunday morning kept repeating one of the hymns: "Nearer My God to Thee." We do not play that side of the record any more.

 Conducted by Raymond P. Sloan

Doctors Are Generous Givers

Professional fund raiser finds M.D.'s above average in contributing hard cash

GEORGE RADCLIFFE
Senior Campaign Director
Ketchum, Inc.
Pittsburgh

THE fact is—doctors are generous. This simple and heartening revelation will come as a surprise to a considerable body of laymen who, for years, have claimed that doctors as a group are the worst givers to fund raising campaigns, and even poor supporters of fund appeals for the very hospitals to which they are attached.

Quite the reverse is true.

Figures on more than 1000 hospital campaigns in 245 U.S. cities in the last 33 years reveal that the highest per capita contributions to these institutions came from the doctors on their staffs. Take any group of businessmen—florists, grocers, dry cleaners, hotel operators, or what you will—and you find no comparison in the size of giving.

A recent survey (see table) of half a dozen major hospital campaigns confirms this. It shows that $928,661 was contributed by only 601 doctors. In analyzing these six appeals (for a combined goal that totaled more than $5,000,000) it was found that doctors had contributed almost 18 per cent of the total.

The average gift, as shown in the table, was $1545—a tidy sum any way you look at it.

Another example of big giving by doctors is the medical staff fund raising campaign now under way at Jefferson Medical College and Hospital in Philadelphia—the largest such campaign I know of. Jefferson has 456 men on its staff and faculty. Of these, about 100 earn salaries of $5000 or less in the preclinical departments, and another 100 have only thin ties with the institution.

Yet this staff and faculty accepted a quota of 15 per cent of a $4,500,000 goal for a hospital addition—and they are raising it!

When the staff first accepted its own quota of $675,000 under the leadership of Thomas A. Shallow, professor of surgery at Jefferson, there were more who scoffed than cheered the effort. But within a month, Dr. Shallow and his assistants had classified the entire staff, built an organization, solicited 83 per cent of their men, and raised $545,000, or an average of $1442 per staff member. And they're still going.

The financial problems faced by today's doctor are often overlooked by those inclined to criticize the physician's giving record. Many volunteer workers on hospital campaigns have condemned loudly the doctors who have "not given enough" to support

DOCTOR PARTICIPATION IN SIX RECENT HOSPITAL CAMPAIGNS

Hospital	Goal of Fund Drive	Total Donated by Doctors	Doctors' Share of Goal	Number of Doctors Donating	Average Donated by Doctors
Aultman Canton, Ohio	$1,097,855	$196,710	17.9%	165	$1,192
Hackensack Hackensack, N.J.	1,750,000	267,245	15.2	150	1,781
St. Luke's Kansas City, Mo.	1,000,000	202,616	20.2	125	1,620
Mercy Muskegon, Mich.	450,000	123,160	27.3	73	1,687
Newark City Newark, Ohio	400,000	60,600	15.1	39	1,553
Sewickley Valley Sewickley, Pa.	550,000	78,330	14.2	49	1,598
Recapitulation	$5,247,855	$928,661	17.7	601	$1,545

This article is being published simultaneously in the June issues of The MODERN HOSPITAL and Medical Economics.—ED.

what laymen consider to be the doctor's "workshop."

True, some doctors do not give adequately to vital community causes. But the same can be said of some businessmen.

In the doctor's case, however, the public has developed the attitude that all physicians are wealthy and should, therefore, be in the vanguard of fund raising campaigns. An economic study of the American physician shows that his *net* income is less than the public believes. There are some topflight men, of course, who earn sizable incomes. Some surgeons, for instance, net $100,000 or more a year. But for every one in this bracket, there are hundreds with modest incomes. In 1949, the Department of Commerce reports, while nonsalaried U.S. physicians averaged almost $12,000 net, a third of them netted less than $7000, a quarter netted less than $5000.

Nor is the public fully aware of the other factors affecting the doctor's ability to give. While in the case of a business concern, everyone realizes that its gross volume does not represent the net income of the owner, people are inclined to overlook completely the hefty operating expenses of the doctor.

MUST EARN A FAIR RETURN

There's also the factor of the time and money spent on his education, which is equivalent to the capital investment in a business. And according to all tenets of good business, this investment must earn a fair return before a true net profit can be shown.

Finally, the M.D. suffers more from poor paying clients than does almost any business or professional man. He is often the first to be called and the last to be paid—if, indeed, he is paid at all. He devotes a great deal of time to out-and-out charity cases (especially if he is on the staff of a hospital) and he frequently comes to the aid of anonymous accident victims. It has even been argued that in terms of time and skill he donates so much to the community that it is unfair to count on *any* cash gifts from him.

Despite these factors, however, doctors have demonstrated their generosity in hospital campaigns spectacularly. In this they seem to agree with other Americans who feel that hospitals must be kept from state control and that the only way to do it is to make certain they are adequately financed through the free contributions of free people.

WILLIAMS: FEE SPLITTING

(*Continued From Page 69*)

Doctor X found an alternative solution, by paying his debt to nature; he died of coronary thrombosis.

In the first two years of the Columbus Surgical Society, its auditor turned up three men using two sets of books, for the society and for income tax purposes. The Bureau of Internal Revenue imposed moderate assessments of $10,000 to $15,000 on them, mainly as the result of disallowing their business deductions of splits paid out.

Funds to pay for the society's annual examination of the surgeons' financial records are raised from annual dues and special assessments. The society retains one of the largest national firms of accountants, Ernst & Ernst, at a cost in the past of about $1800 a year. It should be noted, as Ernst & Ernst representatives emphasize, that "this is not an audit, but a review of the records by accounting experts."

About the middle of April, the assigned auditor requests and obtains copies of income tax returns and through the summer months reviews them. He also looks at the surgeons' cancelled checks for quarterly installments and for final payment of income tax. He watches for the relationship of gross income from one year to the next and the size of salary deductions on Form W-2, the Treasury Department's withholding statement covering wages paid to employes. He analyzes travel and entertainment deductions. Selecting doctors at random through the year, he makes spot checks of their accounts receivable cards and patient ledger cards. He does not look at case records, which involve the confidential doctor-patient relationship. He frowns on cash receipts. The temptation to offer a split is strong when a doctor has a big roll of bills in his pocket.

"In the first year," remarked the auditor, "a good many doctors were disturbed about having an examination of their accounts, but later they came to accept it with surprisingly little criticism. The method of enforcement is basically psychological. We are not informers, and are only interested in whether the doctor has split fees. The society had found a way of making doctors do something they always wanted to do."

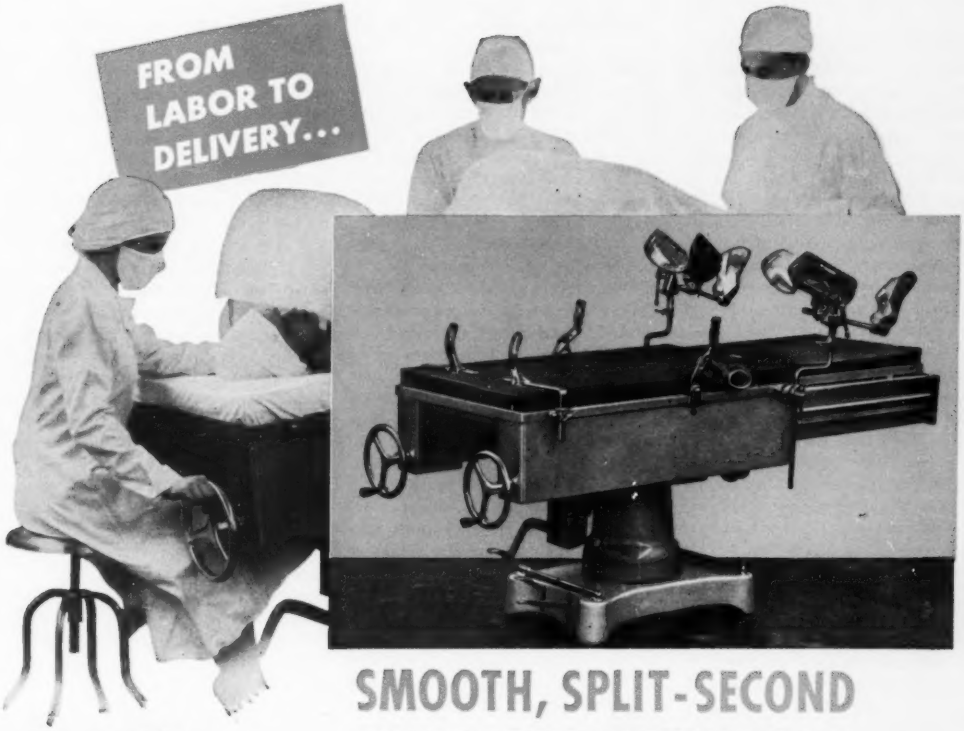
Since the upheaval period, events have gone so smoothly that the auditor's number of reviews has been reduced from the total membership of about 120 to 40, or one-third of the members. This one-third includes all the officers.

All is calm on the Columbus medical front now, and one no longer sees knots of doctors in hospital corridors, beside parked cars or on curbstones knocking or praising the "Purity League," as the society was also dubbed. At present, only one general surgeon in Columbus is outside the fold, and he has shown signs of acquiescence.

Sound out a typical general practitioner on what he thinks of the Columbus Surgical Society, on the other hand, and you will discover he is still "burned up." This applies to competent general practitioners who did not build their practices on fee-splitting as well as to colleagues who were hurt by the reform.

One point of objection on the part of the general practitioners, according to a spokesman, was that the surgeons took unilateral action against them: "The surgeons lost an opportunity of making friends with the general practitioners by not holding open medical meetings on the problem. Besides, many of the general practitioners were away in service."

To this, one of the founders replied: "There was no other way to accomplish this reform except by unilateral action. In any meeting of the county medical society, fee-splitting general practitioners would have had fee-splitting surgeons far outvoted. The G. P.'s beefed about us railroading them while they were away in service, but the argument is not really pertinent. The G. P.'s who wanted to do right are still our friends and, furthermore, we experienced no lack of friendship among the approximately 100 young general practitioners attracted to Columbus when they got out of the army. They never had split fees and were happy



SMOOTH, SPLIT-SECOND *HEAD END* CONTROL!

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to find they didn't have to in Columbus."

One thing that did rankle general practitioners, and with some justification, is that in their statements the spokesmen for the Columbus Plan tended to put the blame for the evil of fee-splitting on the G. P.'s, on the basis that it was a "shakedown" in which the referring physician, if one surgeon would not operate on a patient, would shop around to find one who would. As one leading G. P. pointed out, fee-splitting originates as an offer of money by the surgeon to obtain patients and to build up a practice; here, the initiative and prime responsibility lie with him. Surgeons argue that this is not correct, however, once the fee-splitting system is established. They hold the argument is a futile one, like the arrival order of the chicken and the egg. Who is the greater sinner, the briber or the bribed?

In any event, the reformers achieved their goal.

G.P.'S WERE NOT HELPED

One important criticism of the Columbus Plan is that it did not meet, and was not designed to solve, the problem of either educating the public on the value of the general practitioner or endeavor in any way to improve his competence and stature as a doctor. The American Academy of General Practice, for example, has been organized in recent years to rescue the declining prestige of the general practitioner and defend him against the inroads of specialism.

Oddly enough, it has been traditionally assumed that the justification and perpetuating factor in fee-splitting was that it produced a more equitable distribution of the patient's dollar; yet, it is not evident among Columbus' 700 physicians that the loss of the split has worked any real economic hardship on the general practitioners.

It is true, as one hospital administrator remarked, that they complain of difficulties in collecting from the patient for preoperative and postoperative services in surgical cases, and also complain because most Columbus hospitals do not allow them to assist in operations, a subterfuge for a split. But, according to one general practitioner, "The big objection of the general practitioner is not lack of income but the lack of importance assigned him. The problem is not money but prestige."

His observation is borne out in a general way by a Department of Commerce-American Medical Association survey of medical incomes. This showed the average net income of all private physicians in Columbus in 1949 to be $14,164 as compared to a national average of $11,858. As a matter of fact, in income Columbus physicians ranked eleventh among those of the nation's 32 largest cities, well ahead of doctors in Boston, Chicago, New York, Cleveland, Philadelphia and Washington, for example.

While the surgeons did get to keep their entire fee as the result of the reform, there were apparently no marked jumps in their incomes. As a matter of fact, some of the founder members of the society suffered sharp declines in their volume of operations and, hence, income.

To what extent the patient public has benefited from the Columbus Plan is a question difficult to answer. One benefit would be in reduction of high fees for surgery. There is a difference of opinion among surgeons in Columbus, which has the reputation of a "low fee" town, as to whether eradication of fee-splitting has had this effect. The going rates for operations, $100 to $150 for appendectomies and $150 to $200 for hysterectomies, remain about the same as 10 years ago, according to some surgeons. Since prices on almost everything else have approximately doubled in the same period of time, they contend that people in Columbus have had a reduction in the cost of their surgery. Others state, however, that there has been an upward trend in surgical fees of about $25 to $50 an operation. One thing is obvious: fee-splitters did not cut their fees in half when they stopped splitting.

Another surgeon cited a probable gain for many a patient. Where a general practitioner used to advise him, "Mr. Jones makes a good income so you can charge him a good fee for his wife's operation; make it $300 or $400," the same G. P. in the absence of a split will say, "Mr. Jones has a modest income, so please keep the fee down."

Another benefit would be in the reduction of unnecessary or, at best, optional operations. Said one founding member, "The greatest attribute of the society is the stopping of the removal of normal tissue." This may be true, but one of the city's leading pathologists said that he has not been aware of any change in the margin of diagnostic error among the hospitals and the surgeons for whom he examines surgical specimens.

The question of accuracy in diagnosis may touch on the point made by one of Columbus' leaders in surgery. The chief weakness of the Columbus Surgical Society's plan to control fee-splitting, he said, is that it did not concern itself with a doctor's ability to operate, or whether he was actually qualified as a surgeon. While the society now functions much as any similar organization, for the scientific and cultural edification of its members, it has not at any time imposed qualifications of surgical training or experience on its members, he pointed out.

All evidence, however, points to the conclusion that Columbus, reputed to be one of the worst fee-splitting communities in the country before the plan was put into effect, has had a five-year cure of the cancer of fee-splitting. Said the Internal Revenue agent in charge in Columbus: "We have had no recent trouble from doctors of medicine." An Ernst & Ernst auditor: "Fee-splitting in Columbus is negligible." A hospital administrator: "Conditions are infinitely better." A prominent surgeon: "The progress report after five years is that the line is being held. Fee-splitting is minimal, but some surgeons are getting more practice than their ability would merit."

TAX MEN SWING A CLUB

Other than the fact that it is possible for doctors to police themselves if they are willing to play rough, possibly the most significant fact to emerge in the experience of the Columbus Plan is that the Bureau of Internal Revenue now swings the biggest club against fee-splitting. This is the interpretation of some of its agents, following the Columbus example, that it is now against public policy to allow business deductions of split fees. This point of view is shared by the American College of Surgeons, which recently went on record and notified the Commissioner of Internal Revenue that it did not consider fee-splitting a legitimate business expense of surgical practice. The college speaks for more than 17,500 surgeons. With his hand thus strengthened, it may be that the commissioner will, in due time, direct his agents to break the back of fee-splitting. The fee-splitter's only out will be to conceal income and risk charges of tax evasion.

A

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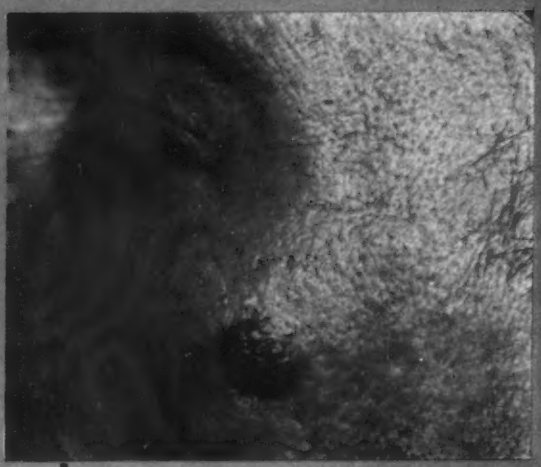
D



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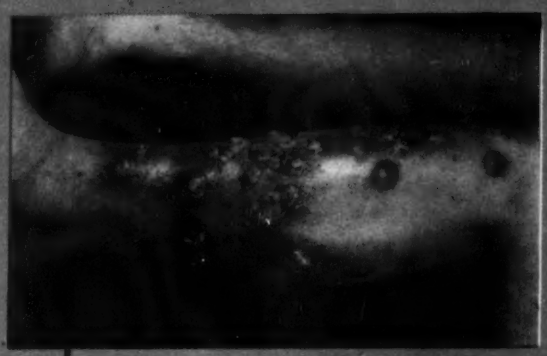

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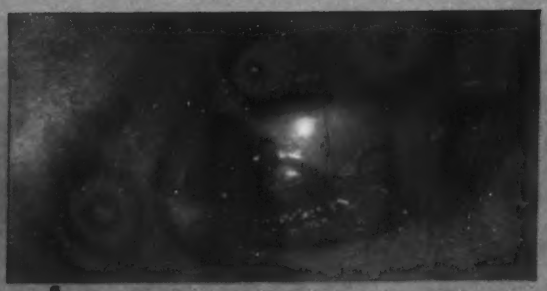

A. Congenital ichthyosiform erythroderma.

B. Pigmented basal cell epithelioma.

C. Cheilitis exfoliativa.

D. Basal cell epithelioma.

E. Bromoderma.

F. Blue nails, congenital abnormality of heart.

G. Dermoid cyst of eye with hair sticking out tangential to eyeball.

H. Lichen sclerosus et atrophicans.

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Conducted by Robert F. Brown, M.D.

How the MEDICAL SOCIETY can help the HOSPITAL

R. M. CUNNINGHAM Jr.

OUR assignment here is to examine ways in which the medical society can help the hospital. The fact that we are having such a discussion at all implies two assumptions—first, that you want to help the hospital and, second, that the hospital needs help. Possibly both these propositions require some further consideration.

Do you want to help the hospital, really? Certainly there are some doctors who talk and behave in a manner that would indicate the contrary. We hear, for example, of doctors who are fearful that hospitals may dominate or control the practice of medicine. These doctors might be more interested in changing hospitals than in helping them. From Blue Cross we get reports about doctors who hospitalize patients primarily in order to shift the burden of payment for diagnostic services from the patient to Blue Cross, and then let charges accumulate so that it is the hospital, and not Blue Cross, that takes the loss. There is a reasonable doubt that these doctors really want to help the hospital.

IT'S ONLY A SMALL FRACTION

On the whole, however, those who are hostile or indifferent to the hospital are only a small fraction of the medical profession. Most doctors whose views on the subject are known to me take the sensible view that the hospital is an indispensable tool of medical practice today, and it is better to have a good tool than a bad tool. Just as it is better to have an efficient office assistant than an inefficient one, and better to have a car that runs smoothly than one that breaks down when you need it, it is better to have a hospital that is well equipped and staffed by competent people than one that is run down and fails to function properly when you need it. You may, understandably, regret the fact that you have to have such a complicated and often seemingly unmanageable tool as the hospital in order to do your work effectively, and you may regret even more keenly the fact that this particular tool has been developed under community and church and government ownership rather than under *your* ownership, but you face the fact that you can't put a million volt x-ray machine in your little black bag, and you can't possibly replace the hospital that is owned by the community or the church or the government with one that you own yourself, so you accept the hospital as it is and you want to help it. The tool is yours to use, if not yours to possess, and so you want it to be a good tool.

The other half of the proposition, "Does the hospital need your help?" answers itself. The hospital needs your help in the same way that a lathe needs help from its operator or an airplane needs help from its pilot. Without you it is nothing. If you abuse it or use it carelessly, it won't do your work efficiently, and it may crash in ruins. But if you understand it and take good care of it and use it wisely it will give you the kind of service you have to have in order to perform your function in society; it will improve with use, and you need never be concerned about the fact that it doesn't actually belong to you, in the sense that your office equipment and your stethoscope and your other personal effects belong to you.

How can you bring about this result? In what ways can you help the hospital and thus make it a better tool for you to use? In order to answer these questions I think we must examine the hospital as an economic phenomenon in our society, and find out what its problems are.

HOSPITAL IS A MISFIT

First of all, it is important to understand that the hospital, as a business, is a misfit in a capitalist society, because it is not a truly capitalist institution. Hospitals are frequently compared to hotels and, in fact, they are often designated as "hotels for sick people," but actually they are different from hotels in the same way that the Federal Security Agency is different from the Metropolitan Life Insurance Company. Both organize vast amounts of money and thousands of people toward a common objective, but the purpose in one instance is to serve society and the purpose in the other instance is to make a profit. Both are good purposes. As a capitalist institution, the hotel may be operated by the capitalist standard: Whatever produces a profit is good, and what produces a loss is bad. Obviously, this standard is no good in the hospital, and yet the hospital has to exist in a capitalist society and is often, in fact, governed by trustees who fail to understand fully that the profit standard is not an accurate measure of its success or failure. As a business, the hospital may be compared to a department store in which the merchandise is ordered by accident, the customers

Condensed from a talk presented at the annual secretaries-editors conference of the State Medical Society of Pennsylvania, Harrisburg, Pa., March 7, 1952.

are hauled in and held against their will, and the employes are supervised by a group of strangers over whom the management has little if any control. I'm not sure exactly how to describe that, but it's certainly not business as most of us know it.

Consider for a moment the plight of management in this hybrid institution. In business, management seeks constantly to buy cheap and sell dear. In the hospital, management is frequently compelled to buy dear and is always obligated to sell cheap. In business, management can do anything that is legal to attract desirable customers, and it rejects those it regards as undesirable. In the hospital, circumstance decides who the customers shall be, and there isn't much that management can do about it if a disproportionately large number of them turn out to be undesirable, or insolvent. In business, management exerts full authority over the employes—again within legal limits (and the limits aren't nearly as wide as they were 15 years ago, but they're still pretty wide). In the hospital, management hires the employes, but the most important employes are supervised by a group—the doctors, that is—which often shows little understanding or sympathy for management's problems. In business, profits may always be reinvested in plant and equipment, and any improvement which offers profit-making promise may be financed with venture capital—some of which is still available even in these tax-ridden days. In the hospital there are no profits or anticipated profits with which to finance improvements, and yet management has a moral obligation to make replacements and capital improvements at a rate which would bankrupt most businesses—often knowing that they will only increase operating losses!

FACED WITH FINANCIAL PROBLEMS

What all of this adds up to, of course, is that hospitals today are faced with acute financial problems. The prices of everything that the hospital buys have skyrocketed upward in the general inflation, and the price of hospital labor, which uses up some 65 per cent of the hospital dollar, has gone up more than the general price index for the whole economy, because hospital wages, which were substantially below the general industrial level, have had to catch up as hospitals competed for labor in a full employment market. Of course, rates have gone up too, but rates have a tendency to lag behind costs in the upward spiral, and there is a growing resistance to further increases as rates go up. Some of the resistance comes from doctors. As costs and rates have gone up, heavier and heavier taxes have cut into the amounts hospitals receive in philanthropic gifts from individual donors, and the number of indigent patients for whom the hospital receives payment at less than cost has grown steadily larger. Fortunately along with these grim developments have come a couple of favorable ones: The number of insured patients has gone up constantly, and corporate contributions to hospital capital fund campaigns have increased while individual contributions were dwindling. Along with all these changes, of course, one must remember that every new development in medical science makes itself felt in the hospital, invariably in terms of increasing complexity and expense of hospital care, rather than the contrary. Consider the changes that the antibiotics have brought in hospital nursing service, for example, at a time when nurses have been in short supply and the nurse's working week was being driven downward from 48 to 44, then to 40 hours!

The first thing you can do to help the hospital, then, is to understand that its management problems are almost unbelievably complicated, compared to those of most businesses, and stop telling yourselves and one another, whenever something happens in the hospital that displeases you, that "Things would be different around here if we only had some efficient management!" And you can help the hospital even more if you will stop telling your patients the same thing, or acquiescing when they tell you. This is another significant way in which the hospital is different from business. In business, management is solely responsible for its own public relations; it controls the people and things and methods that add up to the public's impression of what the business stands for. In the hospital, *you*, and not the management, are responsible for public relations to a large extent. You share in the control of the people and things and methods, for one thing, and, more importantly, the patients look to you for an interpretation of their hospital experiences. If a patient complains to you about the size of his hospital bill, for example, and you reply in effect, "Yeah, if those people only knew what they were doing!"—what chance does the hospital have to defend itself? If, on the other hand, you can explain something about the complexity and expense of modern hospital care and justify the charges, you may have made an important contribution to the stability of the voluntary hospital system. The difference between a population that thinks hospital management is inefficient and hospital costs are extravagant, and a population that thinks hospitals are worth what they cost, may ultimately be the difference between a population that votes for socialized medicine and one that votes against it. In my opinion, the contributions you make to strengthen the hospital system we have today are at least as important in this respect as the contributions you make to political propaganda designed to hold socialized medicine at arm's length.

BE SYSTEMATIC ABOUT IT

If, as medical societies and as individual doctors, you decide that you do want to help the hospital in this important matter of interpreting its needs and problems to your patients, I suggest that you should be systematic about it. The first step, obviously, is to inform yourselves; in most hospitals this means finding out a lot of things that you don't now know about the hospital as a business. I have suggested the nature of some of these things; in every hospital you are connected with you should know the specific facts of revenue and expense, charges, collections, employment and other business details—certainly not simply in order to do a better job of kibitzing or second-guessing the management in all its problems, but chiefly so that you can understand the problems yourselves and interpret them for your patients. I am aware that there are some hospital boards and administrators who don't want to give you this kind of information, who think it is none of the doctor's business what the hospital does with its money. I'm not sure what you can do in a situation like this except to show as much interest as you can, and hope for the best. I think hospital administrators who take this attitude are wrong, and, fortunately, they are in the minority. Most hospital people welcome the intelligent concern of the doctor. This doesn't mean that the administrator can drop everything else and talk to the doctors one at a time about his problems. The

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1. Greene, G. G.: Kentucky M. J. *50*:8, 1952.
2. Stevenson, C. S., et al.: Am. J. Obst. & Gynec. *61*:498, 1951.

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necessary exchange of intelligence must be accomplished on a planned, group basis. I don't believe you can accomplish much by inviting the administrator to attend your hospital staff meetings and then giving him 10 minutes for a statistical report of hospital operations following an hour or two of clinical discussion — though certainly this is better than not having him there at all. It seems to me rather that administration should have a regular place in the program for your county medical society and hospital staff meetings, so that periodically an entire meeting is devoted to the presentation of hospital business information and discussion of hospital business problems.

Such discussions could not fail to give the hospital needed help. A better understanding of what the hospital's business operations are will be likely to illuminate your own functions and needs in the hospital. Your needs for new equipment, for example, are more likely to bear a reasonable relationship to expense and use than they would if you didn't know or care about the hospital's business. I am not suggesting here that doctors are in the habit of recklessly demanding hospital equipment that they don't need and can't use, but I am suggesting that your equipment demands should frequently be studied more carefully than they are from the standpoint of the hospital's income and expense. The same thing is true of most items that the hospital purchases under medical supervision. The amount of money that is tied up in drug inventories in hospitals, for example, is simply staggering, and yet many hospitals have discovered that they can cut their drug inventories by a third or a half or more by establishing a standard formulary of a few hundred needed items and eliminating purchases made to suit the individual fancies of 50 or 100 doctors with preferences for particular brands and packages of the same item. With your help, hospitals can achieve the economies that are possible through standardization and simplification of countless other products in the fields of medical, surgical and nursing supply; without your help, there really isn't much the hospital can do along these lines except struggle uphill against heavy odds and probably antagonize you in the process.

In addition to helping the hospital to economize in its operations, physicians certainly have an important responsibility in the community-wide aspects of hospital economics. From the standpoint of society generally the most economical patient is the one who doesn't go to the hospital at all, or who stays there the shortest possible time if he does have to go. Thus your participation in the development of preventive programs, the extension of outpatient services, the establishment of rehabilitation departments in hospitals and similar activities will contribute toward making your communities self-sustaining. By adding to the already high cost of medical care, the physician who hospitalizes patients who might have stayed home, or lets his patients remain in the hospital longer than they need to be there, is permitting an extravagance which few communities can afford in our time.

DON'T WANT TO INTRUDE

We are concerned here chiefly with the hospital as a business, but it should certainly be obvious that a closer relationship between the medical society and hospital administrations will also be productive in other ways. Many of you have been troubled in recent years by what you conceive to be a tendency of hospital trustees and administrators to interest themselves, or to interfere, in matters that are strictly professional. I can assure you that hospital administrators and trustees are troubled about this too. With rare exceptions they have no wish to intrude in any way on your affairs, unless the evidence is overwhelming that you are failing to supervise your own membership adequately in such matters as fee splitting, elimination of unnecessary surgery, and limitation of surgical privileges to known competencies. Lay hospital people, believe me, enter these areas reluctantly and with many misgivings; they do so not with any idea of disciplining doctors but only because they feel accountable for what happens to the people you are treating in hospitals for which they have an owner's responsibility, and only when the doctors themselves have failed to take action.

If you don't believe this, if you think that hospital administrators and trustees are actualy meddlesome laymen bent on seizing control of the practice of medicine, you won't be persuaded to the contrary by anything I am telling you here, but I think you will be persuaded to the contrary if you do meet periodically with the hospital people in your communities and ex-

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change information and advice about such common interests as these. In a few places, this effort at integration has been carried a step further and medical societies have held joint meetings with local and regional hospital associations. The evidence on both sides is that such meetings have been helpful.

In addition to the light it may shed on individual problems and relationships, closer medical-hospital liaison might produce some interesting new ideas. Here is something we have badly needed: a willingness to apply in the field of your financial and administrative and social and political relationships the same spirit of inquiry that has characterized your scientific performance and has made possible the miraculous proliferation of medical science in our time. This is the spirit which believes, in the memorable words of Thomas Jefferson, that "as new discoveries are made, new truths disclosed, and manners and opinions change with the change of circumstances, institutions must advance also, and keep pace with the times. We might as well require a man to wear still the coat which fitted him when a boy, as require men in civilized society to remain ever under the regimen of their barbarous ancestors."

Notes and Abstracts

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

Effects of Atropine on the Central Nervous System

ATROPINE, one of the oldest of the medicinally useful alkaloids, has for centuries been extracted from such plants at Atropa belladonna (Jimson weed) and henbane and used in galenical mixtures. Mein, in 1831, isolated this alkaloid in pure form and it has been since identified as racemic hyoscyamine.

PARASYMPATHETIC BLOCKING AGENT

Alkaloids of the atropine type represent almost ideal blocking agents for the parasympathetic division of the autonomic nervous system because, in therapeutic dosage, the action of parasympathetic fibers on smooth muscle, cardiac muscle, and glands is prevented whether excitatory as in the gut or inhibitory as in the heart.

As is well known, the normal function of the body is maintained by double innervation of autonomic organs, sympathetic and parasympathetic; the fibers of one system usually are opposite in function to that of the other. The postganglionic fibers of the parasympathetic system are cholinergic, that is, acetylcholine or a similar substance acts as a transmitter between nerve fiber and effector organ. This function of acetylcholine at cardiac muscle, smooth muscle, and gland is termed its muscarinic action.

The blocking effect of atropine is exerted at the junction between parasympathetic fibers and effector organs, not by preventing the release of the acetylcholine-like transmitter but by preventing the response of the effector itself. One might expect, therefore, the action of atropine in the body would be to alter the normal autonomic balance and to reduce or abolish such symptoms of parasympathetic hyperirritability as bradycardia, smooth muscle spasm, hypersecretion, miosis, depression of oculocardiac reflexes, asthma and the like. It is a matter of clinical experience that atropine and other parasympathetic blocking agents have less effect on normal muscle and gland than on hyperactive organs.

NERVE GAS ANTIDOTE

In addition to blocking the effects of parasympathetic stimulation and of injected acetylcholine-like compounds, atropine has been shown more recently to be an important therapeutic agent in the treatment of war "nerve gas" poisoning. The compounds are inhibitors of the enzyme cholinesterase, which functions in the body as a catalyst in the rapid breakdown of acetylcholine to choline and acetate. The function of acetylcholine in transmission of nervous stimulation depends on the rapid hydrolysis of the ester after its release. One would then expect that at sites where acetylcholine is active, inhibition of the enzyme hydrolysis would cause an accumulation of acetylcholine and thus effects similar to those seen after its injection occur. Atropine might be assumed to block the response of peripheral effectors to the acetylcholine preserved in this way. The effects of many anticholinesterase compounds including eserine, prostigmine, diisopropylfluorophosphate and the war gases have indeed been shown to be similar to those of parasympathetic overstimulation and to those following the injection of acetylcholine.

The anticholinesterase compounds, however, have central as well as peripheral actions which are also prevented or reduced by atropine. The rôle of acetylcholine in central synaptic transmission is at the present not yet clearly defined. But reasoning from the action of atropine in blocking peripheral symptoms, one might postulate a similar mechanism by which atropine exerts its influence in the central nervous system.

Only fragmentary evidence is at present available for study. But it has been shown that at high dosage atropine and similar alkaloids may block ganglionic effects of acetylcholine and central effects of injected acetylcholine. This action is ordinarily not seen because of the great specificity of atropine as an antagonist of muscarinic effects.

GENERAL CENTRAL EFFECTS

The central effects of atropine and related alkaloids have been variously reported as both stimulant and depressant. There is evidence to suggest that there is some cortical depression, depression of the upper brain stem, and stimulation of certain medullary centers by atropine given in low doses, while scopolamine is more generally depressant. At higher doses there are restlessness, irritability, disorientation, delirium and hallucinations.

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1000 and 5000; Gantrisin Syrup, 0.5 Gm per 5 cc (one full teaspoon)
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and 10 cc ampuls containing 2.0 and 4.0 Gm of Gantrisin,
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may represent release of higher centers from inhibitory controls just as stimulation of medullary respiratory and vasomotor centers may be due to release of control exerted by hypothalamic autonomic nuclei. The fact that the cerebral toxic syndrome of atropine resembles that of alcoholic inebriety supports this view.

Clinical impressions of central effects, therefore, cannot distinguish site and mode of action of drugs active at various levels. Newer neuropharmacological technics are now becoming more widely employed to investigate the effects of these alkaloids, and evidence is gradually being accumulated both as to loci of action and the possible importance of a central acetylcholine blocking action.

The effects of the alkaloid on brain metabolism as measured by oxygen consumption of brain cells have been measured in isolated tissue preparations and *in vivo*. In both atropine appears to reduce oxidative activity.

EFFECTS ON THE EEG

An important tool for the study of brain activity was developed by Berger, which measures the electrical activity of the cerebral cortex. The electroencephalogram serves to indicate the state of cortical activity. Numerous studies have made it possible to distinguish various rhythms which take their origin at subcortical levels as well. It has been shown that the tendency of the belladonna alkaloids to produce drowsiness is accompanied by the appearance of high voltage spindles similar to those appearing during natural sleep. There is good evidence that these spindles result from depression of the brain stem activating center described by Magoun and his collaborators, suggesting that atropine may have a selective action in depressing this region of the brain stem reticular formation. Since spindling is immediately abolished by eserine and other anticholinesterase drugs, this evidence is suggestive of a central acetylcholine blocking action. Spike-like potentials in the EEG produced by local application of acetylcholine to the cortex or by application of the anticholinesterases have also been shown to be abolished by intravenous administration of atropine, as are the convulsive patterns in the EEG's of animals given diisopropylfluorophosphate and the frank convulsions precipitated by this compound.

In preparations of single and multisynaptic pathways through the midbrain and cortex there has also been evidence that acetylcholine enhances synaptic transmission as do the anticholinesterase compounds. The effect of acetylcholine on these preparations can be blocked by atropine given close arterially in large doses. These data are further evidence for a central blocking of acetylcholine by atropine and related alkaloids.

EFFECT ON REFLEXES

Study of the effects of atropine on reflexes whose central connections are at different levels of the cerebrospinal axis is another method of localizing the site of action of the compound. For example, the patellar reflex, or knee jerk, is mediated over a two neuronal spinal pathway. It may be elicited by tapping the patellar tendon and altered by simultaneous stimulation of either the ipsilateral or contralateral sciatic nerve. While there are conflicting data in the literature on the depression of the reflex, in normal doses there seems to be no action on these spinal pathways. Direct and reflex excitability in the medulla through cardioinhibitory and respiratory centers has been determined by use of the perfused isolated head technic, and there has been no positive evidence that doses of 10 mgm. of atropine alter these centers directly. The linguomaxillary reflex, on the other hand, probably is mediated over the fifth and seventh cranial nerves through pontine reticular formation pathways, and we have been able to confirm reports of the depression of this reflex by atropine.

CLINICAL APPLICATION

The exact localization of the sites of action of belladonna alkaloids in the central nervous system is of particular interest to the clinician because, of the classic drugs employed in hyperkinetic muscle states, atropine remains the most effective.

A starting dose of 0.4 to 1 mgm. per day of atropine with an increase to 10 to 20 mgm. per day as tolerance to the drug is developed seems to reduce the tremor, rigidity and excessive salivation of Parkinson's syndrome in man. The data previously cited as well as production of a Parkinsonian-like tremor by subjecting monkeys to lesions of the ventral tegmentum of the mesencephalon suggest a possible site of the action of the belladonna alkaloids. They may prevent tremor by depression of the brain stem in the area of the lesions, but clear evidence on this point is not yet available.

It is often mentioned that special preparations of belladonna such as the wine extract of the roots (the Bulgarian cure) offer certain advantages, but there is no reliable evidence to this effect. Scopolamine does seem to be fairly effective in abolishing tremor.

Conflicting clinical reports are appearing concerning the usefulness of certain synthetic compounds whose only rationale for trial are atropine-like effects at peripheral sites or chemical resemblance to atropine itself. These include panparnit, diparcol, parsidol and artane and the antihistaminic compound benadryl, an ethanolamine ether whose structural similarity to a portion of the atropine molecule will be pointed out later.

Various other spastic and rigid states have also been treated with these alkaloids, and variable degrees of symptomatic relief are reported. But the widest use of the central actions of belladonna alkaloids is in pre-anesthetic medication where both the depression of secretion and the sedative and tranquillizing properties are utilized. By far the commonest is the combination of atropine or scopolamine with morphine sulfate; the latter combination is often referred to as "twilight sleep" and was formerly used extensively as an obstetrical anesthetic. With the development of newer sedative drugs of greater potency and fewer unpleasant side effects, the use of the belladonna alkaloids to quiet restless and agitated patients is no longer indicated under usual circumstances.

TOXICITY

The classic description of belladonna toxicity, "hot as a hare, blind as a bat, dry as a bone, red as a beet, and mad as a hen," refers to the common toxic symptoms of atropine overdosage: fever, cycloplegia or paralysis of accommodation, blocking of secretions, cutaneous vasodilation and central stimulation.

The first cases of Jimson weed poisoning were reported in the United States, according to Goodman and Gilman, in 1676. "This being an early Plant was gather'd very young for a boiled salad, by some of the Soldiers sent thither, to pacifie the troubles of Bacon; and some of them ate plentifully of it, the effect of which was a

very pleasant Comedy for they turned natural Fools upon it for several Days . . . and after Eleven Days, returned themselves again not remembering anything that had pass'd."

The margin of safety between effective and toxic doses of atropine is one of the widest among the alkaloids. The side effects of low dosage with the compounds are not usually serious enough to be of importance clinically. A small dose, 0.5 mgm. per man, of atropine usually produces dryness of the mouth by blocking salivary secretion and may also slow the pulse initially by central stimulation. As peripheral actions of the drug develop over 10 to 20 minutes, the pulse is accelerated by the blocking of vagal control of the heart. Gastric, bronchial and sweat gland secretions may be reduced. There are only rare instances in which somatic and psychic signs of overdosage have been reported with 0.5 to 1 mgm. of atropine.

In a large group of volunteers given 1, 2 and 3 mgm. doses, there were few serious signs and symptoms of toxicity at the 2 mgm. level. A dosage of 2.5 to 5 mgm. is followed by marked xerostomia and thirst, hoarseness, nausea, headache, flushing and a prolongation of gastric emptying time. One may usually consider that doses of 5 to 10 mgm. in a person not tolerant to the drug will cause severe intoxication with extremely rapid heart rate, hoarse and difficult speech, pupil dilation to maximum, restlessness, garrulity, confusion and mania. At least 100 mgm. is required for lethal effect in man as a rule and there is a report of a navy corpsman who recovered after taking 1 gram of atropine.

There have been conflicting reports on the effects of age on susceptibility to atropine. There seems to be little concrete evidence to support the assumption of increased vagal tone and increased atropine tolerance in the very young. Carefully controlled experiments indicate that individual susceptibility is very variable in all age groups. The average M.E.D. or effective dose in suppressing salivation per kilogram body weight reported in babies under 1 year of age is 0.016 mgm./kgm. and from 1 to 3 years, 0.014 mgm./kgm. In older children up to 12 years, from 0.020 to 0.022 mgm./kgm. has been reported as the effective dose.

The ratio of oral to parenteral dose was approximately three in all age groups. Increasing dosages over that depressing salivation tend to produce flushing, mild erythemia and finally fever resulting primarily from loss of sweating. These data show that children are not more tolerant to atropine than adults. Indeed, atropine poisoning occurs most frequently in children.

Diagnosis of atropine poisoning may be aided by the administration of 10 to 30 mgm. of mecholyl. If flushing, salivation, sweating, lacrimation and such symptoms do not occur, belladonna poisoning is the most probable diagnosis.

Treatment is primarily symptomatic. Pilocarpine may be administered to counteract peripheral effects, and short acting barbiturates in small doses for central nervous system symptoms. Larger doses or long acting barbiturates are contraindicated because of the added danger of potentiating late atropine respiratory depression.

CHEMICAL STRUCTURE

Atropine has been identified as a tropic acid—tertiary amino alcohol tropine ester. The l isomer is apparently the natural compound, racemized during extraction. This optical isomer is responsible for most of the peripheral actions of atropine in man, as Cushny was the first to show, while both l and d forms are active in the central nervous system of mammals.

Scopolamine or l hyoscine, also extracted from solanaceous plants, was first purified in the early years of this century. It has been shown to contain the same tropic acid residue as atropine, but scopine replaces the tropine moiety. In homatropine, on the other hand, it is the tropic acid residue which has been replaced by a mendelic acid ester.

Other compounds of this series are quaternary ammonium derivatives. Novatrine is the methyl bromide of homatropine, eumydrine the methyl nitrate derivative of atropine, and buscopan is scopolamine n-butyl bromide. The quaternary derivatives seem to have few central actions, which would agree with the findings of many workers that quaternary ammonium compounds pass the blood-brain barrier only with difficulty.

During World War II, it became possible to synthesize atropine, and the development of these processes has made possible synthesis of a whole series of new compounds, each differing from atropine in relative potency,

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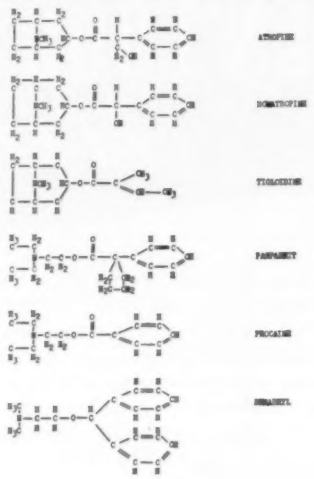
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

Chemical Similarities of Certain Compounds Having Central Effects Similar to Those of Atropine



duration of action and selectivity. Many are clinically useful for one or another site because reduced affinity for other organs or systems eliminates unpleasant side effects. None of the newer compounds, however, seems so far to be as potent as atropine itself in the treatment of tremor and spasticity, and the search for compounds more selective in inhibiting central sites, particularly in the brain stem, is being continued.

There has been a recent suggestion by Trautner and Noack that pharmacological effects of this series, including the central actions, depend on esterification of the scopine or tropine base with aromatic acids (mendelic, tropic, atropic). Typical properties were lost if simple aliphatic acids replaced the unsaturated aromatic or aliphatic acid moieties.

The table indicates a possible essential structure in compounds which resemble atropine in alleviating tremor and rigidity in Parkinsonism. A tertiary nitrogen, two or three methylene groups, an alcoholic bridge, and an unsaturated aliphatic or aromatic ester seem to be important. This structure is demonstrated by both tigloidine, a natural alkaloid which seems to have a therapeutic effect in Parkinsonism, and procaine which also has this action but is not practically useful because of its instability. The grouping $-CH_2CH_2-N(CH_3)_2$ or $N(C_2H_5)_2$ found in many of the antihistaminics, if linked with unsaturated acids, might have a steric resemblance to the essential structure of atropine, which would explain the similar central effects of some of these compounds which have been reported. (See table.)

SUMMARY

Atropine and the belladonna alkaloids are almost perfect blocking agents for the parasympathetic nervous system. By blocking the response of peripheral effectors to parasympathetic stimulation and to injected acetylcholine, they prevent the muscarinic actions of acetylcholine. There is evidence that, particularly at higher doses, atropine-like compounds also block the actions of acetylcholine at ganglia of the autonomic system and within the central nervous system.

Clinical applications of the central effects of atropine include treatment of nerve gas poisoning, hyperkinetic muscle states, pre-anesthetic medication, and, rarely, sedation.

The toxic effects of the compounds are those of peripheral parasympathetic blockade and central depression of the brain stem as well as possible stimulation of the cortex. There may be a structural common denominator among atropine-like compounds, antihistaminics and certain synthetics useful in suppressing tremor which may serve as a basis for the development of drugs more selective for these actions.—ELLEN EVA KENG, M.S.

The Dietitian's Job Is Administration, Too

STANLEY A. FERGUSON
Superintendent
City Hospital
Cleveland

GOOD health is one of the most popular subjects in the United States today. From all sides we are bombarded with advice and instruction on how to achieve or to maintain a state of good health. As individuals our health is a matter of concern from the cradle to the grave, and even before the cradle stage is reached the health of the unborn child is not overlooked.

The swift and dramatic advances in medical science have had a profound effect on America's hospitals. No longer are they the haven of the poor or the refuge of last resort when all hope has passed. Public confidence in medicine and its principal workshop, the hospital, has projected both into the realm of big business. A few figures from the 1951 "Administrators' Guide" issue of *Hospitals* will help to indicate the size of this industry. In 1950 the total expense of *all* hospitals in the United States (governmental, mental and tuberculosis included) was $3,600,000,000. More than 1,000,000 full-time employes were required to man the hospitals' services.

THEY SPEND $700,000,000

What has all this to do with dietitians? A great deal, for the dietitians in hospitals are directly responsible through their dietary services for perhaps 20 per cent of these total expenditures or the rather staggering amount of approximately $700,000,000. As for personnel, the dietitians direct the activities of probably 100,000 people, or 10 per cent of all employes in hospitals. Consequently, they are involved in big business, and the plans they make and the operations they direct have an important bearing on the services and the economic framework of hospitals. The dietitian's is a big rôle, and to do a good job she has to give an outstanding performance.

The purpose of all hospitals is to make available to the patient and his physician the personnel and facilities needed to treat illness. The complexities of present-day medicine have greatly increased the activities within the hospital, and too often in our difficult day to day efforts to keep these activities staffed and moving, the focal point of attention—the patient—is easily overlooked. Our task of furnishing adequate dietary service among all the other essential needs is difficult, but we must always keep in mind that in the long run the patient's needs must be foremost in our planning and direction. What the hospital is has often been diagrammed as a triangle with the patient at the top supported by a multitude of services beneath fanning out to a broad base. Perhaps it would be more realistic to turn the picture around and depict the patient at the bottom point of a triangle supporting all these services. The patient is our reason for being.

The dietary service is one of the important elements in the proper care of the patient. The dietitian's job is not to furnish the kind of meals served in a hotel but to provide food of a type and nature which will aid in the medical treatment of the patient. This is important whether the patient is seriously ill, or not, for, after, all the patient who has nothing wrong with his appetite and presents no therapeutic dietetic problem is still our responsibility and the dietitian probably has to work doubly hard to give him food which meets his needs and demands.

The task of the dietary department in providing a proper food service to patients is complicated by the fact that the department cannot maintain full control of all steps in the feeding process. It may exercise full control over the purchase, preparation and distribution of the food, but somewhere along the line where the food reaches the patient the completion of the service must be taken over by the nursing department. The point at which further responsibility for food service is transferred to the nursing department varies from hospital to hospital and no single pattern is possible.

CAUSES OF DISAGREEMENT

This sharing of responsibility, so to speak, causes a great deal of confusion and disagreement between the two departments. And, unfortunately, since the dietary department is primarily concerned and identified with the feeding process, that department will reap all the criticism which may arise, even though the conditions or service under criticism lie in that stage of service beyond the department's control. All of this means that dietitians must strive doubly hard to gain the cooperation of the nursing and medical staffs and their understanding of the part dietary service plays in the patients' care.

The dietitian must be careful to decide in conference with these services the limits of responsibility which each group assumes. The physician needs to know what services are available to him for the proper dietetic treatment of his patient, and the nursing staff needs to know just how the dietitian has planned to nourish the patient. Just how she will be able

Condensed from a discussion presented at the American Dietetic Association meeting, Cleveland, October 1951.

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to enlist such understanding and cooperation must in large measure be left up to the dietitian. No longer is it entirely possible for the administrator of the average hospital today to handle all the interservice relationships which so vitally affect the patients' care, and the heads of the major services—and the dietary service is certainly one of these—must assume the responsibility for maintaining such relationships. We must be constantly reminded that explanations of why satisfactory accomplishment of stated goals or policies is not achieved serve no useful purpose, and whoever has an administrative responsibility must work diligently to get positive, successful results, no matter what the difficulties.

SHE IS NOT ALONE

The challenge to the dietitian, then, is to get proper food service to the patients in spite of the inherent difficulties which hospital operation present. But, after all, the dietitian is not alone in what she may feel to be a dilemma, because the same difficulties face heads of other major semiprofessional and nonprofessional departments. All must take certain steps in order to assure maximum, satisfactory service.

What are the basic steps of administration which the dietitian must recognize and do something about? She must plan, organize and direct. She cannot do an adequate job if any one of these is overlooked. Certainly, organization and direction cannot be successful if proper planning has not preceded them. Likewise, good planning accomplishes nothing if organization and direction are weak, and it goes without saying that in spite of planning and organization, lack of proper direction can only provide poor service.

I don't know whether most dietitians consider planning as part of their job, or whether they feel that the administrator should decide what he wants done, notify them of the plan, and then leave the organization and direction to them. As the head of a major service, the dietitian should welcome the opportunity to prepare the plan of operation of her department, for, after all, who should know better than the dietitian what proper dietary service should be? Others may indicate that they know more about it than the dietitian does, but for her to admit such a state of affairs by failing to lay the plan for her service can only make the eventual results poor by comparison with a well planned service.

A plan is a proposed method of action or procedure, and in this definition the important word is "proposed" which in its present tense means "to set before the mind" or "to picture in the mind." That is a hard thing to accomplish, and because it is hard to plan perhaps that is why all of us take the easy way and avoid making plans, leaving our eventual operating program to chance and circumstance. Certainly, the dietitian is not in a position to know all the policy changes which may affect her departmental operations in future periods, and someone—the administrator—will have to advise her of any such changes. But she certainly should know whether her present operations are meeting present plans and she should be in a position to revise and change these plans for future action.

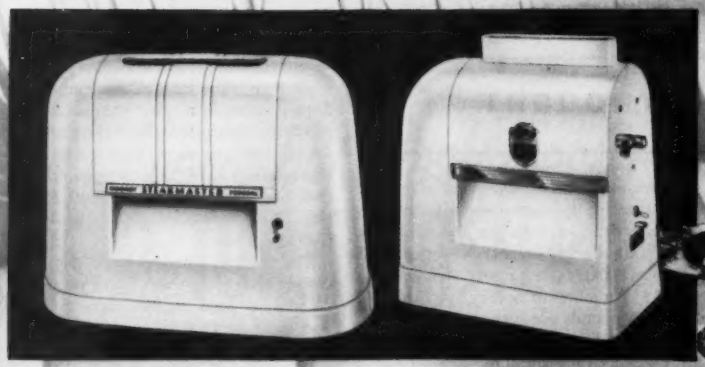
A plan of operation is the basic ingredient of a budget. Too often a budget is considered in terms of the amount of money which has been granted or allowed for future operations. Although the money aspect of a budget is the ultimate unit of measurement, it follows rather than precedes the service plans which the money will provide. Unfortunately, we have a tendency to look upon a budget as an allotment of funds determined without rhyme or reason and certainly insufficient to operate an adequate dietary service. Budgeting should not and need not be left to chance, but unless the dietitian has evolved a well worked out plan and presents it to the administrator for his guidance he can only proceed on the basis of past operations and build a budget accordingly.

Once the plan of action or operation is set, the dietitian is in a position to set up the organization which will make it effective. Organization of personnel and facilities will not remain static for the reason that the department head's activities do not remain static. She has to be constantly on the alert to see where changes should be made to reflect changing conditions. Sometimes she is called upon to change quickly, as at present when a shortage of personnel makes frequent revision of the organization necessary. Work loads have to be shifted and new procedures worked out. But then there is the long-range organization job to consider. Here again, looking into the future is not easy but the dietitian will probably have a better organization if she plans for changes than she will if she lets the changes force themselves upon her at a time when she is least prepared to meet the adjustment required.

The third phase of the dietitian's administrative function is to direct the activity which she has planned and organized. This is the part of the job with which all dietitians are concerned most of the time and with which they are most familiar. There is no question that this is the biggest part of the job and the part which causes most of the day to day problems. How to provide an acceptable dietary service from day to day with all the difficulties which are present taxes the ingenuity of the department head, but the over-all, successful operation of the hospital's service depends upon the successful accomplishment of that task.

MUST ASSUME LARGER RÔLE

Inasmuch as it is impossible for the administrator to be intimately acquainted with all of the departmental activities, more and more the department head must assume a larger rôle in the administrative function of the hospital. There is no question that the administrator must recognize the increasing importance of the department head and must encourage her to exercise the administrative functions more fully. He must be ready to keep the department head informed of proposed changes in hospital plans and programs. He must be willing to discuss departmental plans and activities with each department head and rely upon their recommendations for the services they direct. I am sure the busy administrator today needs the intelligent, administrative assistance of his dietitian, and as she demonstrates the ability to handle the administrative functions he will be only too glad to place greater reliance upon her recommendations and activities.



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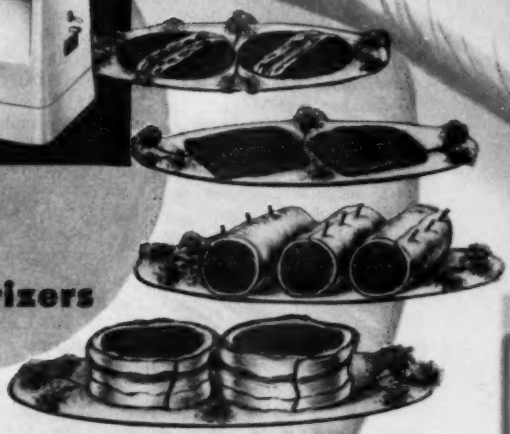

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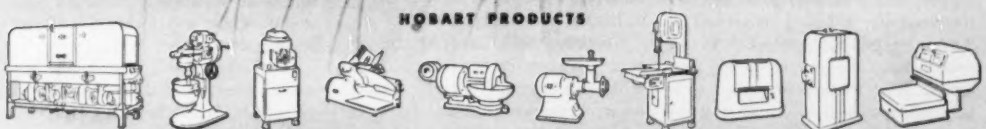

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FOOD FOR THOUGHT

Sandwich Production Manual

A handy tool in dietary management is the new manual for quantity sandwich production issued in May by the American Institute of Baking. Called "Modern Sandwich Methods," the manual emphasizes simplified job methods.

Sandwich making is broken down into the board method for the "to order" single sandwich; the multiple stack method for 30 sandwiches; the bread tray setup, for production-line use, and the production-line method for very large quantity production.

The manual is so bound that it can be set up on the sandwich preparation counter for reference or it can be laid on the counter. A washable cover protects it from easy soiling.

A blueprint for an ideal sandwich center is a part of the manual, worked out on the basis of time and motion studies. Sanitary standards, fatigue lessening surroundings, food handling precautions to prevent loss of freshness and bacterial growth, bread storage suggestions, approximate quantities of bread and fillings needed for average sized portions, and a table of portion scoop sizes add value to the manual.

Probably the page of greatest interest to dietitians is the one containing interesting arrangements of sandwiches on the plate with accompanying cutting cues.

The manual was introduced to food service operators at the National Restaurant Association convention which met in Chicago May 5 to 8. It may be obtained for 25 cents per copy from the Consumer Service Department of the American Institute of Baking, 400 East Ontario Street, Chicago.

Pressure and Broccoli

Whether different steam pressures affect the appetizing qualities and nutritive values of vegetables has been a question of concern ever since the advent of "pressure pans" for home cooking.

Tests with broccoli at the New York State (Cornell) Experiment Station suggest that it is immaterial whether the vegetable is boiled or cooked at different pressures, provided it is not *overcooked*. The broccoli in the tests was as good when plain boiled as it was when cooked at 5, 10 and 15 pounds pressure and rated about the same in three important vitamins—ascorbic acid, thiamine and riboflavin.

The Cornell tests showed that broccoli cooks to the "just tender" stage in 13½ minutes of boiling; in 7 minutes at 5 pounds pressure; in 6 minutes at 10 pounds pressure, and in 5½ minutes at 15 pounds pressure. Thus, it takes about twice as long to boil as to pressure cook broccoli, but the saving in time between pressures is insignificant.

Fruit Candy

The California Experiment Station suggests a variety of simple candy recipes that include fruit:

Popcorn-Fruit Crisp: Ingredients: 1 cup sugar; ½ cup corn sirup; ⅓ cup water; 1½ teaspoons butter; ¼ cup chopped dried fruit or whole seedless raisins; salt to taste; 3 cups popped popcorn. To make: Cook sugar, corn sirup and water to the "hard crack" stage (285° F. on the candy thermometer). Add butter, salt and fruit. Stir well. Stir in popcorn. Spread in an oiled pan to harden. Break or cut into pieces.

Fruit With Marshmallow: Ingredients: 12 marshmallows; 2 cups dried fruit; ⅓ cup chopped nuts. To make: Put ingredients through food chopper together, using the coarse knife. Be sure they are uniformly mixed. Dust the mixture with powdered sugar. Roll out on waxed paper that has also been dusted with powdered sugar. Let stand overnight. Cut into squares and dust with powdered sugar. Variation: Substitute ⅓ cup well drained fruit preserves for the 2 cups dried fruit.

Uncooked Fruit Candy I: Ingredients: 3 egg whites; 2 cups powdered sugar; ¾ cup powdered milk; 1 cup chopped dried fruit; ½ cup chopped walnuts or almonds; ½ teaspoon vanilla. To make: Beat egg whites light. Slowly stir in powdered sugar and powdered milk. Mix nuts and fruit thoroughly. Stir into egg white mixture. Add vanilla. Mix thoroughly. Pour into oiled pan or on waxed paper to harden. Cut into squares.

Uncooked Fruit Candy II: Ingredients: ¾ cup sweetened condensed milk; 4 cups finely sifted powdered sugar; 1 teaspoon vanilla. To make: Warm condensed milk in double boiler until it is thin enough for mixing. Remove from heat. Add vanilla. Add powdered sugar gradually, mixing until smooth and creamy. To each cup of this mixture, add ⅔ cup chopped dried fruit and ½ cup chopped nuts. Mix well. Pour into oiled pan to harden. Cut into squares.

The California station would remind candy-makers that the right utensils as well as good recipes make better and more professional looking candy and also save time on the job. They suggest a candy thermometer to take the guesswork out of judging when candy is cooked to the right stage. It should have a scale ranging from room temperature to 300° F. or above. Kitchen scales also are useful because often ingredients are measured by weight. Other utensils suggested are small food grinder, electric mixer to save time and energy, as well as accurate measuring cups and spoons, shallow baking pans and one or two large cooking spoons. For those who make a specialty of candy-making the station also suggests a sirup hydrometer and a dehydrater or small dryer for candying or glacéing fruit at home.

Frost in the Freezer

It is to be expected that a freezer will need defrosting once or twice a year, when about ½ inch of frost shows on large areas of walls or shelves. Occasionally, however, a freezer gathers frost much faster so that the operator may wonder anxiously whether food may spoil and operating costs mount.

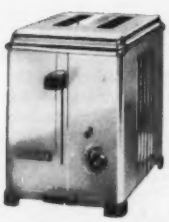
Reassurance on these two counts comes from a recent experiment in the U.S. Department of Agriculture. Dr. Earl McCracken, physicist in household equipment laboratories of the Bureau of Human Nutrition and Home Economics, has tested the effects of letting frost accumulate 1½ inches thick in a chest type of freezer operating at 0°F. With this excessive frost, there was no harmful rise in temperature to endanger the food, he reports. Nor did operating cost rise much.

Nevertheless, says Dr. McCracken, it is still wise management to defrost a freezer periodically, when frost is ½ inch thick. When thicker than this, frost wastefully reduces the food storage space, and makes the freezer inconvenient to use.

If a freezer frosts too rapidly, pay special attention to three management points, Dr. McCracken suggests:

serve hot, fresh toast from the TOASTMASTER toaster in your FLOOR DIET KITCHENS!

4-SLICE MODEL
$94.00



2-SLICE MODEL
$49.00

More and more hospitals are supplementing their main-kitchen toasters with "Toastmaster" Toasters in floor diet kitchen service. Toast for each floor is made in the diet kitchen *on that floor*. So toast always reaches patients hot, fresh, and crisp. That adds appetite appeal, makes the entire meal more enjoyable, means a lot to patients.

Yes, and the time and steps this type of installation saves in toast-making mean a lot to hospital personnel. You'll like the "Toastmaster"* Toaster's completely automatic operation, the sturdiness of its construction, and the ease with which it makes light, dark or in-between toast—just the way each patient prefers it. All you do is dial the color of toast that's wanted.

The 2-slice "Toastmaster" Toaster pops up 125 slices per hour; the 4-slice has an hourly capacity of over 250 slices. You buy the size you need now; then, as requirements grow, it's easy to add a unit that will satisfy any toasting needs—all the way up to 1000 slices of golden-brown toast per hour.

Your food service equipment dealer will be glad to show you all the advantages of the flexible, "put-it-where-you-need-it" "Toastmaster" Toaster. Call him now.

TOASTMASTER
automatic POP-UP TOASTERS

*"Toastmaster" is a registered trademark of McGraw Electric Company, makers of "Toastmaster" Toasters, "Toastmaster" Waffle Bakers, "Toastmaster" Roll and Food Warmers, and other "Toastmaster" Products. Copr. 1952, Toastmaster Products Division, McGraw Electric Company, Elgin, Ill.

Don't open the freezer often r than necessary or leave it open longer than necessary.

Package properly all foods put into the freezer, so that moisture valuable for food quality does not escape and become useless frost.

See that the gasket makes a good seal. If excessive frost accumulates around the opening, that is a warning sign—install a new gasket.

Cooking White Rice

This year's record rice supplies offer plenty of this popular cereal. Though many kinds of rice are on markets, the most widely used still is plain white rice. Research on white rice cookery at the Bureau of Human Nutrition and Home Economics, U.S. Department of Agriculture, shows better, faster, easier and less wasteful ways of preparing rice than many of the old familiar routines.

The following directions may come as a surprise to some:

1. Don't wash rice before cooking unless necessary. It is less likely to be sticky if not washed before cooking. Bulk rice may need "dry cleaning"—rubbing in a towel after husks and poor grains are picked out. If rice must be washed, use very hot water.

2. Cook rice in as little water as possible to retain more flavor and keep texture firm but tender. Rice needs no more than three times its measure of water for cooking—usually less. One cup of uncooked rice makes 3 cups cooked—enough for six servings. For seasoning, allow ½ teaspoon salt for each cup of uncooked rice.

3. Boil rice gently in a loosely covered pan. Rough boiling may break grains and cause rice to boil over.

4. If cooked according to directions, it is unnecessary to rinse rice afterwards.

For *fluffy, dry rice* with each grain standing separate, boil gently until tender, or boil part time, then let the pan stand tightly covered in a warm place so that rice finishes cooking in its own steam.

COVER PAN LOOSELY

Boiling Method. Stir 1 cup uncooked rice into 2 to 2¼ cups rapidly boiling salted water. (Use the larger amount if heat cannot be kept very low.) Bring back to boiling, then lower heat until water is just bubbling. Cover loosely and cook slowly 20 to 25 minutes, stirring occasionally with a fork for even cooking. Remove lid, reduce heat and let rice stand 5 minutes to dry out.

Short-Boil Method. Stir 1 cup uncooked rice into 1½ to 1¾ cups rapidly boiling salted water. Bring back to boiling point, then lower heat until water is just bubbling. Cover loosely and cook slowly 15 minutes. Remove pan from direct heat and let stand 10 to 15 minutes covered tightly. Serve.

Moist rice generally is preferred for patties, croquettes or a molded dish. To have it moist but not mushy, cook in a double boiler or bake in a covered dish in the oven.

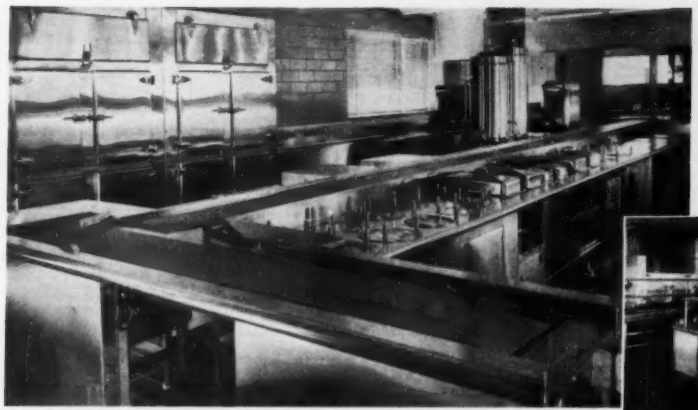
Double-Boiler Method. Stir 1 cup uncooked rice into 1¾ cups rapidly boiling salted water in the upper pan over direct heat. Bring back to boiling and then set upper pan over boiling water. Cook, covered tightly, about 45 minutes or until tender, stirring occasionally for even cooking.

Oven Method. Place 1 cup uncooked rice with a half teaspoon salt in a baking dish. Pour 2 to 2¼ cups boiling water over rice. Cover the dish tightly and bake in a moderate oven (350° F.) about 45 minutes or until rice is tender.

Greatest number of awards

in 1952 Institutions food service contest!

TOP HONORS GO TO 7 BLICKMAN INSTALLATIONS:



HONOR AWARD — *Greenwich Hospital, Greenwich, Conn.* Showing stainless steel tray production unit, with refrigerator, Lowerators and hot food stations.

- ★ Du Pont Hotel
- ★ Beth-El Hospital
- ★ Skidmore College
- ★ University of Michigan
- ★ King's Arms Tavern
- ★ Greenwich Hospital
- ★ Maple Hill Restaurant

MERIT AWARD—*Du Pont Hotel, Wilmington, Del.* Stainless steel cook's table, built-in tray rest.

● With the many fine entries in this year's Institutions Food Service Contest, these installations had to *earn* their awards. In each case, equipment and layout combined to provide efficient operation and a high degree of sanitation. Such prize-winning installations typify the sound planning, good design and fine fabrication which have won 21 awards for S. Blickman, Inc. in 5 years. Smooth, crevice-free surfaces and sturdy, welded structures guarantee ease of cleaning and durability under severe daily use. In terms of *permanence* and low operating cost, Blickman-Built food service equipment is your logical choice, too.

MERIT AWARD — *University of Michigan, Ann Arbor.* Stainless steel cafeteria counter.

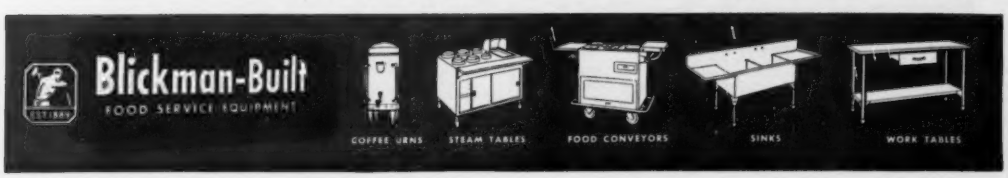
SKIDMORE COLLEGE installation planned by H. Horton & Co., Albany. MAPLE HILL RESTAURANT equipment was planned and installed in cooperation with Charles G. Lincoln & Co., Inc., Hartford, Conn.

Send for illustrated folder describing Blickman-Built food service equipment, available in single units or as complete installations.

S. Blickman, Inc.
1506 Gregory Ave., Weehawken, N.J.
New England Branch:
845 Park Square Bldg., Boston 16, Mass.

MERIT AWARD — *King's Arms Tavern, Colonial Williamsburg, Va.* Stainless steel cook's table.

MERIT AWARD — *Beth El Hospital, Brooklyn, N.Y.* Stainless steel dish tables in dish pantry.



Menus for July 1952

Sarah Suzanne Tweed
Director of Dietetics
Baptist Hospital
Pensacola, Fla.

1 Pink Grapefruit Half Sausage Links • Grenadine Fruit Punch Roast Lamb With Mint Jelly Parslied Potato Cauliflower au Gratin Pear, Cheese Salad Chocolate Pie • Chicken Okra Gumbo Minced Ham on Toast Baked Mashed Potato Carrot, Raisin Salad Frosted Cup Cake	**2** Stewed Apricots Poached Egg • Vegetable Soup Baked Virginia Ham Mashed Potatoes Baby Lima Beans Lettuce Hearts Banana Pudding • Beef Broth Cold Plate: Sliced Roast Beef, Potato Salad, Sliced Tomatoes and Pickles Pear, Cottage Cheese Salad Fresh Berry Cup	**3** Baked Apple Bacon • Cream of Tomato Soup Salisbury Steak in Gravy Oven Browned Potato Cut Green Beans Pineapple, Grated Cheese Salad Vanilla Ice Cream • Beef Soup Cold Plate: Chicken Salad, Deviled Eggs, Spiced Crabapples and Cole Slaw Baked Potato Chocolate Brownies	**4** Frosted Strawberries Scrambled Eggs, Jam • Cream of Vegetable Soup Broiled Fish Parslied Potato Baked Egg Plant Lettuce Hearts With Russian Dressing Watermelon • Cream of Tomato Soup Tomato Stuffed With Tuna Fish Salad Baked Potato Fruit Salad Chocolate Pudding	**5** Grapefruit Juice Poached Egg, Bacon • Chicken Noodle Soup Yankee Pot Roast With Vegetables Fresh Fruit Salad Old Fashioned Bread Pudding • Cream of Spinach Soup Shepherd's Pie Baked Potato Mixed Vegetable Salad Chocolate Ice Cream	**6** Fresh Banana Fried Egg, Canadian Bacon • Jellied Consommé Baked Chicken With Dressing, Gravy French Green Beans Assorted Olives Raspberry Sundae • Chicken Broth Veal Stew With Dumplings Fresh Fruit Cup
7 Applesauce Hard Cooked Egg, Bacon • Chicken Broth Broiled Calves Liver Buttered Rice Buttered Turnip Greens Tomato Salad Coconut Cake • Cream of Spinach Soup Creamed Turkey on Toast Baked Potato Molded Pear in Lemon Gelatin Salad Peanut Butter Cookies	**8** Cantaloupe Fried Egg, Bacon • Pineapple Juice Fantail Shrimp With Catchup Cups Parslied Potato Steamed Okra, Vinegar Cole Slaw Watermelon • Green Split Pea Soup Welsh Rabbit on Toast Baked Apples With Cherries and Honey	**9** Apple Juice Poached Egg, Bacon • Vegetable Soup Roast Veal Leg Mashed Potatoes Green Peas Banana, Nut Salad Gingerbread With Whipped Cream • Chicken Consommé Cold Sliced Chicken Baked Potato Lettuce Hearts With 1000 Island Dressing Apple Tarts	**10** Stewed Fresh Pears Bacon, Grape Jam • Cream of Mushroom Soup Roast Beef With Gravy Buttered Rice Mashed Yellow Squash Mixed Vegetable Salad Deep Dish Peach Pie • Vegetable Soup Broiled Beef Patty Macaroni and Cheese Sliced Tomato Salad Fruit Cup	**11** Stewed Cinnamon Apple Breakfast Rolls • Fresh Vegetable Soup Deep Sea Scallops With Tartare Sauce Baked Potato Spinach Tomato, Lettuce Salad Lemon Cake • Fresh Shrimp Cocktail Scrambled Eggs Baked Potato Fresh Fruit Salad Sugar Cookies	**12** Fresh Tangerine Sausage Links, Jelly • Chicken Noodle Soup Broiled Beef Steak Sliced Harvard Beets Mashed Potatoes Mixed Vegetable Salad Chocolate Ice Cream • Cream of Spinach Soup Chicken Salad on Lettuce Leaves With Tomato Quarters and Deviled Egg Pear, Cottage Cheese Salad Cup Cake Topped With Ice Cream, Sirup
13 Grapes Canadian Bacon, Jelly • Fruit Cup Baked Turkey, Dressing Mashed Potatoes Sliced Carrots Celery Hearts, Olives Walnut Ice Cream • Vegetable Soup Creamed Eggs on Toast Asparagus Salad Marble Cake	**14** Fresh Banana Fried Egg, Bacon • Chicken Broth Broiled Liver Escalloped Potatoes Green Peas Lettuce Hearts With Roquefort Cheese Dressing Apple Upside Down Cake • Cream of Tomato Soup Tuna Fish Pie Baked Potato Fruit Salad Sugar Cookies	**15** Stewed Apricots Sausage Links, Jam • Cream of Vegetable Soup Roast Beef au Jus Buttered Flaked Rice French Green Beans Chef's Salad With French Dressing Chocolate Pudding • Chicken Broth Chinese Chow Mein With Crisp Noodles, Soy Sauce Grapefruit Salad Fruit Cup	**16** Pineapple Juice Hard Cooked Egg • Chicken Noodle Soup Veal Stew Mashed Potatoes Buttered Spinach Tomato Salad Boston Cream Cake • Chicken Broth Beef Patty Baked Potato Waldorf Salad Fruit Cup	**17** Grapes Sausage Links, Jelly • Beef Broth Roast Lamb Parslied Potato Buttered Green Lima Beans Tomato Salad Apple Pie • Cream of Potato Soup Macaroni and Cheese Mixed Vegetable Salad Peanut Butter Cookies	**18** Orange Half Breakfast Rolls • Fresh Vegetable Soup Fried Fillet of Fish With Tartare Sauce Mashed Potatoes Buttered Whole Beets Lettuce Hearts With Russian Dressing Fresh Peach Shortcake With Whipped Cream • Shrimp, Okra Gumbo on Rice Mounds Julienne Carrots Cole Slaw Fresh Fruit Cup
19 Strawberries Poached Egg, Jelly • Chicken Broth Broiled Pork Chops Parslied Potato Chopped Spinach, Egg Banana, Nut Salad Chocolate Ice Cream • Pineapple Juice Escalloped Ham and Potatoes in Casserole Buttered Vegetables Sliced Tomato Fresh Fruit Cup	**20** Baked Apple Fried Egg, Date Muffins • Jellied Tomato Consommé Broiled Chicken Sweet Potato Escalloped With Apples Sliced Carrots Strawberry Sundae • Beef Broth Cold Plate: Sliced Roast Beef, Potato Salad and Deviled Egg Melon Ball Compote	**21** Orange Half Hard Cooked Egg • Split Pea Soup Broiled Calves Liver Mashed Potatoes Mashed Rutabagas Peach, Cheese Salad Applesauce Cake With Hard Sauce • Vegetable Soup Italian Spaghetti With Meat Balls Beet, Green Bean Salad With French Dressing Fresh Fruit Cup	**22** Stewed Apricots Scrambled Eggs • Tomato, Okra Soup Broiled Beef Patty in Gravy Escalloped Cauliflower With Peas and Eggs Lettuce Hearts With 1000 Island Dressing Banana Cream Layer Cake • Cream of Potato Soup Grilled Canadian Bacon With Pineapple Tossed Vegetable Salad Strawberry Tarts	**23** Stewed Apples Bacon, Jelly • Vegetable Soup Baked Ham Potatoes O'Brien Escalloped Tomatoes With Cabbage and Bacon Asparagus, Egg Salad Lemon Chiffon Pie With Whipped Cream • Cream of Tomato Soup Cold Plate: Sliced Roast Beef, Tomato Salad and Potato Chips Pumpkin Custards	**24** Grapefruit Half Sausage Links, Jelly • Fresh Vegetable Soup Broiled Pork Tenderloin Buttered Rice Buttered Peas Cole Slaw Chocolate Ice Cream • Beef Broth Sliced Chicken Baked Potato Waldorf Salad Sugar Cookies
25 Applesauce Scrambled Eggs, Jelly • Fresh Vegetable Soup Fried Fillet of Fish Mashed Potatoes Buttered Beets Lettuce Hearts With Russian Dressing Peach Shortcake With Whipped Cream • French Onion Soup Shrimp Creole on Rice Julienne Carrots Cole Slaw Fresh Fruit	**26** Stewed Prunes Sausage Links, Jelly • Cream of Tomato Soup Turkey à la King on Toast Mashed Potatoes Green String Beans Sliced Tomato Salad Strawberry Ice Cream • Fresh Vegetable Soup Baked Vermicelli and American Cheese Casserole Tossed Chef's Salad With French Dressing Coconut Pudding	**27** Fresh Frosted Peach Canadian Bacon • Chilled Apple Juice Baked Virginia Ham Mashed Sweet Potatoes Ford Hook Lima Beans Assorted Olives Chocolate Sundae • Beef Broth Creamed Chipped Beef, With Egg Slice Fruit Cup	**28** Frosted Strawberries Fried Egg, Bacon • Breaded Veal Cutlets With Cream Gravy Parslied Potatoes Green Asparagus Peach, Cottage Cheese Salad Chocolate Layer Cake • Green Split Pea Soup Cold Sliced Chicken Baked Potato Mixed Vegetable Salad Fruit Cup	**29** Baked Apples Sausage Links, Jelly • Chicken, Okra Gumbo Stuffed Baked Pork Chop Buttered Rice French Green Beans Pineapple, Cream Cheese Salad Vanilla Ice Cream • Chilled Pineapple Juice Cold Plate: Chicken Salad, Tomato Quarters and Deviled Egg Coconut Pudding	**30** Fresh Frosted Peach Poached Egg, Bacon • French Vegetable Soup Salmon Loaf With Cream Sauce Parslied Potato Green Peas Cole Slaw Orange Sherbet • Chicken Broth Macaroni and Cheese Tossed Green Salad Jelly Roll
31 Orange Half, Scrambled Eggs • Cream of Mushroom Soup, Broiled Calves Liver, Mashed Potatoes, Buttered Broccoli, Pear, Cottage Cheese Salad, Butterscotch Pie • Vegetable Soup, Toasted Cheese Sandwich, Tomato Salad, Fruit Cup					

Ready-to-eat or cooked cereals served on all breakfast menus.

Build Obsolescence Out of the Building

GEORGE BLUMENAUER
Architect-Hospital Consultant
Kansas City, Mo.

HOSPITAL objectives, equipment and methods of treatment change as medical and clinical points of view change or clarify, and as planning standards and equipment are improved. Therefore, in planning a new structure we must anticipate the inevitable impacts of change and obsolescence. Is obsolescence deferrable? Can its impacts be eased by proper planning and construction technics?

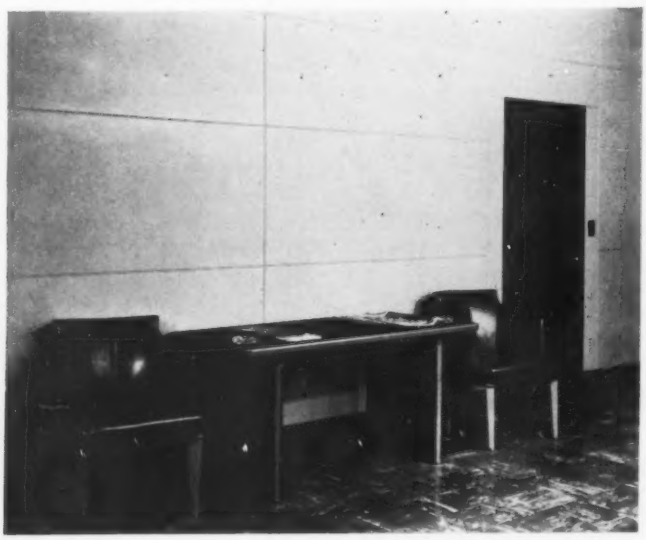
Two problems which face those who would erect hospitals are: (1) the obsolescence rate in buildings and equipment, and (2) the possibility that a future generation may not like our hospitals and may prefer to erect its own structures rather than continue with those it has inherited. Obsolescence of a plan, a structure and a point of view is the deadliest ill that a hospital builder has to guard against. Time is no respecter of structures or gadgets. Obsolescence may destroy the usefulness of an otherwise sound structure and its equipment.

Were it possible to create a plan, a tool or a kind or scope of service which could not be improved, obsolescence would be a minor factor. The problem, then, would be mainly one of maintaining and replacing a facility as its parts became damaged or worn. But inventive minds which devise ways to improve the plan and the tool and thus to broaden their scope of usefulness are ever at work and create most of our obsolescence problems. For in this process, while we recognize that the mere fact of "change" in itself is virtueless, nevertheless an existing plan, tool and method may become economically unjustifiable in competition with a more perfect plan, an improved tool and a broader, more efficiently operated scope of service. It is thus with our hospitals. This is a fact that planners and administrators must weigh with humility.

The rate of change and obsolescence in hospitals during the past half century is matched somewhat by the rate of change in transportation on the ground, in the air, and in auditory and visual transportation of sound and color. The end of this process is not in sight!

We must realize that the economic concept of today's hospital rests on a foundation supplied by a period of economic inflation and in history we have abundant evidence that such swings toward inflation are ever followed by reverse swings of the pendulum. Construction costs now are about 176 per cent above those of mid-June 1946. We must realize also that a newly constructed hospital—which may have cost a large sum and is an imposing structure in its community—may have become obsolete in certain of its aspects while still in the planning stage. The administrator and planner, therefore, who weigh with care the probable benefits accruable from "planning for obsolescence control" will perform a service of inestimable value to their client.

Equipment becomes obsolete as new



Movable walls can be erected either horizontally or vertically. The finished wall presents a surface that is easy to clean.

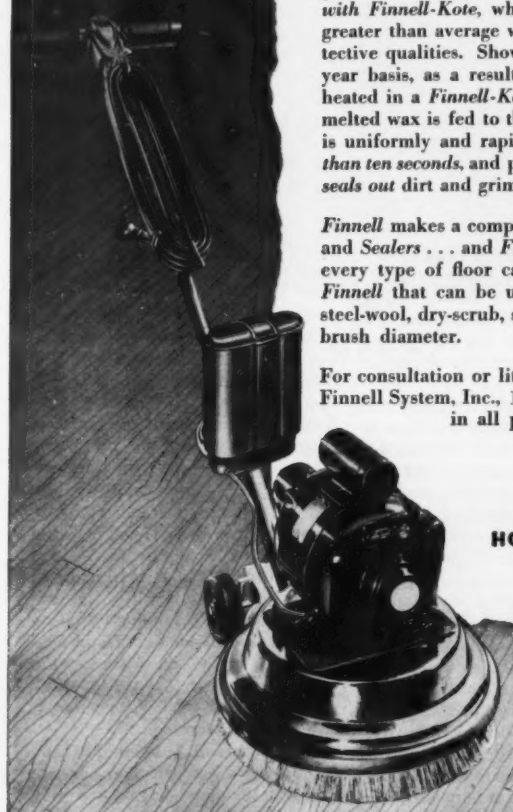
Why Wax Floors So Often?

"To protect the floors and simplify maintenance," would be a logical answer. However, these purposes can be served, and *still* the frequency of waxing can be reduced, by using *The Finnell Hot-Wax Process.* In this process, *Finnell-Kote Solid Wax* is used, and it is applied mechanically with *Finnell Equipment.*

Hot-waxing affords greater penetration—allows the wax to *flow* into the pores of the floor—and thoroughly utilizes the wax solids. *Hot-waxing with Finnell-Kote,* whose genuine wax content is three to four times greater than average wax, produces a finish unique in wearing and protective qualities. Shows substantial savings in labor costs, on a year-to-year basis, as a result of fewer applications required. *Finnell-Kote* is heated in a *Finnell-Kote Dispenser* attached to a *Finnell Machine.* The melted wax is fed to the floor through the center of the brush ring, and is uniformly and rapidly spread by the revolving brushes. *Sets in less than ten seconds,* and polishes to a beautiful, non-skid finish that actually *seals out* dirt and grime. Contains genuine Carnauba.

Finnell makes a complete line of *Waxes* . . . also a full line of *Cleansers* and *Sealers* . . . and *Floor-Maintenance Machines* and *Accessories* for every type of floor care. The machine shown below is a *600 Series Finnell* that can be used to apply wax, polish, wet-scrub, scrub rugs, steel-wool, dry-scrub, sand, and grind! Four sizes: 13, 15, 18, and 21-inch brush diameter.

For consultation or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1406 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.



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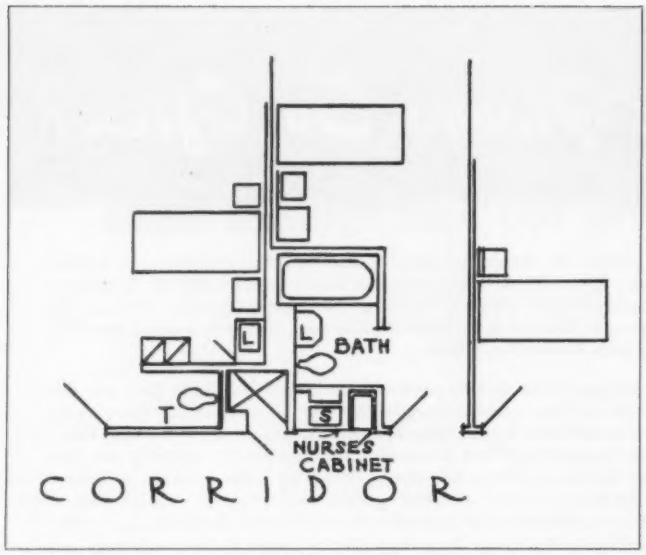

Design for a concentrated and accessible plumbing unit.

equipment, which will do a task better and more economically, becomes available. An established utilization of a planned space or area becomes obsolete as more effective ways are found to treat the patient's ills, as the hospital's scope of service in its community is broadened better to serve the normal needs. The facility which cannot adjust effectively to developing or newly accepted requirements becomes obsolete! It is as simple as that. The casualties of this economic process are to be seen everywhere.

At no time in history has the march of obsolescence taken a toll so heavy in existing hospitals as during recent decades, *e.g.* the last 30 years. The problem of defeating this process in many ways seems less a matter of erecting and equipping increasingly expensive new structures than of adjusting our thinking to realities, and to taking an over-all view of basic needs of the population. A community ultimately should get its money's worth out of a hospital which it constructs and uses. What factors will enable it to do so?

1. Evolution in the Use of Floor Area and Space. Properly built exterior walls and the skeleton framing of buildings may have a useful period of indeterminate, often great, length; it is primarily the interior areas and the fenestration which suffer obsolescence. In hospitals most problems and their solutions are related first of all to the treatment of patients, the prevention of disease, and the lowering of the percentage of congenital defectives.

Often it is a perplexing, costly task to remodel and successfully convert an outmoded hospital into one that will be efficient in its operation and services, although its physical structure may be sound. It often seems that the task might have been simpler and more economical if, in the original planning, provision had been made for the probable future replanning of the space, the mechanical equipment and its accessibility. In short, foresight in planning a new structure should provide the groundwork for possible replanning of various areas and spaces.

Modern prefabricated sectional partitioning may afford great flexibility wherever it is necessary to resubdivide space in some areas of hospitals. With this type of partitioning the replanning of space usually can be effected with a minimum of debris, confusion and time, as compared with that caused by making changes in structure where masonry and plaster partitioning were used. Heavy wear may be expected in areas such as corridors, patients' rooms, clinics, kitchens and management offices, and floor surfacing in these areas will wear out eventually.

Applied floor finish materials, such as rubber tile, linoleum, asphalt tile, cork, compressed organic fibre and, in some areas, a bituminous surface offer a wide choice in practical use and decorative effects, in addition to such finishes as troweled cement and terrazzo. Applied surfaces are easily maintained and at need are readily replaceable, as compared with types of floor finish which are integral with the construction. A suitable type of applied, easily replaceable floor surface can be selected to meet different area requirements.

CONSIDER WAYS AND MEANS

A consideration of the question of means which may be used in any future replanning and reequipping of interior space in hospitals should be basic in designing a new hospital. The probable need for resubdivision of space ought to be a part of the original concept to allow for the remodeling which may be necessary in order to keep abreast of constantly developing needs and standards.

In dealing with fenestration the seasoned planner soon perceives that windows are not an unmixed blessing; problems as well as advantages reside in them. The window's principal function is to admit light and fresh air. Balanced against this is the fact that in room interiors wall space has value. Excessive fenestration limits the flexibility of partitioning, and may cause a new problem of controlling daylight and sky-glare. Furthermore, the cost and maintenance of window shades, venetian blinds, curtains and draperies must be considered, as well as the cost of window washing and repairs.

The stay of a patient in the general hospital usually is not for such long duration that the kind or area of windows is a vital matter, where services otherwise are good. The average standard competitive window, therefore, is usable and practical.

2. Mechanical Systems. Mechanical systems in hospitals have a limited period of usefulness, but their scope of use tends constantly to broaden. Generally it develops that after 25 to 35 years of service the problem of maintenance and replacements in plumbing, heating and electrical installations attains increasing importance. Problems arising from the increasing use of air conditioning are yet to be fully appraised. Metals suffer their particular

How Fires Start . . .

Carelessness

According to statistics, fire strikes an average of 3 hospitals daily. Moreover, the belief that lightning never strikes twice in the same place is consistently disproved.

Fires are habitual repeaters, starting again and again in the same kinds of places . . . kitchens, basements, laundry chutes, storerooms and closets. And, from the same causes . . . which turn out to be just plain human carelessness, in most cases. For example, the ordinary guy who unthinkingly tosses away a lighted match.

How Fires Are Stopped . . .

Grinnell Sprinklers

Education does a world of good to prevent fires from starting. But until human behavior is perfect, your best protection lies in automatic control.

The surest control is with Grinnell Automatic Sprinkler Systems, which check fire at its source, wherever and whenever it may strike, with positive certainty.

In hospitals, there is a moral obligation upon management for the utmost protection of life and property. So, for your own sake, be sure the lives for which you are responsible are protected with Grinnell sprinklers, your assurance of automatic fire protection.

GRINNELL FIRE PROTECTION SYSTEMS

MANUFACTURING • ENGINEERING • INSTALLATION • SINCE 1870

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afflictions and the likelihood of obsolescence in working parts, valves and fixtures, primarily, is limited only by the limits of human inventiveness in devising improved equipment and fixtures. The conversant planner learns from many sources that there is a wide variation in the quality and period of usefulness of different kinds of materials and equipment — the cheapest product is not necessarily the best economic risk.

When improvements or replacements must be made in a mechanical system, the question of the location and accessibility of the parts arises. The obsolescence rate in electrical systems is accelerated by growing demands for electric power to operate mechanical equipment, lighting and treatment units. Electric lighting fixtures and methods have undergone great changes, and the end of this process seems far off. Generous provision should be made in the original planning for adding future circuits, outlets or equipment in anticipation of future contingencies. Metal raceways in the floor system for future changes or extensions of electric services will provide for flexibility in this respect.

3. Labor Saving Standards. The labor saving problem is an old one, but the never ending search for solutions to it is always prefaced with the question of "How?" The four practical phases of labor saving in the hospital are: (1) saving construction labor by means of thorough analytical and critical architectural and engineering planning; (2) perfecting the orientation of the various units in their working relation to each other, and planning the area and volume units so as to save the hospital personnel labor in operating the institution; (3) predicating mechanical facilities comprising plumbing, electricity and heating so that maintenance and repairs can be effected with a minimum of "mess" and disturbance, and so that in future remodeling or conversions strategically located outlets for mechanical services may be found, and (4) considering the ultimate question of demolition and salvage.

A facility which demands a large volume of wasted steps[1] and other waste of personnel energy and labor should be appraised critically. Today an hour saved is more than a dollar earned. A hospital that is wasteful of labor must add the cost of the waste to its charges per patient day or else recover this part of its income from sources other than patients. Its position when competing with more efficiently planned plants may be notably weak.

4. Physical Deterioration of a Property. The action of time and normal wear and tear progressively affect a property's value and usefulness. Physical deterioration may help to speed its obsolescence. Certain qualities are vital in planning and construction to retard physical deterioration. Movement in the structure caused by settling and the expansion and contraction of materials, such as concrete, masonry, steel and floors, resulting from thermal variations should be controlled; moisture penetration into the structure and extremes of thermal variation should be guarded against. Deterioration in structures which results from causes such as these is more prevalent than is commonly realized. Surfaces exposed to the elements should be of an extremely resistant nature.

Exterior walls which admit mois-

[1] Blumenauer, George: Wasted Steps: What Do They Cost? South. Hosps. 19:35 (November) 1951.

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ture[2] to interior areas may cause irreparable damage to a structure, and the condition may escape notice until the harm is far advanced. Such an occurrence is often a forerunner of other ills.

5. Surfaces Easy to Maintain. Irrespective of a structure's age, its form, color and surfaces are the features which make impressions on our senses. Age itself does not necessarily engender or speed the process of obsolescence. One may observe, for instance, a cathedral whose age is 700 years, which has suffered little from obsolescence, while in its shadow may be found structures only a few years old, wherein obsolescence has destroyed or greatly reduced the usefulness and economic value. The question of obsolescence becomes one of how well a structure serves its purpose and how well it fares in competition with other structures performing a like service.

Floors normally are subject to hard use, and exposed surfaces soon may show evidence of wear. Some kinds of surfaces, such as troweled cement or terrazzo, usually are troublesome to replace, but applied materials, such as asphalt tile, rubber tile, and linoleum, can be readily replaced. This fact is of far-reaching importance in selecting construction materials.

Wainscotings often are necessary and, in areas where intensive use is expected and ease of maintenance is desirable, glazed terra cotta has virtues that recommend it, when compared with applied wainscoting materials.

In much of the hospital interior it is the painted surface which we see. The useful life of painted and decorated surfaces tends to be uncertain and limited. In judging the comparative values of different kinds of painting materials, a period of at least five years of satisfactory service does not seem too much to expect. Let others experiment! When the long-term point of view is kept in the foreground of planning and construction, the future will bring fewer unpleasant surprises. Responsible manufacturers and dealers hope to see their materials and installations give good service.

Much may be said in favor of various kinds of materials that do not require painting but have usable natural wearing surfaces and satisfy the esthetic requirement.

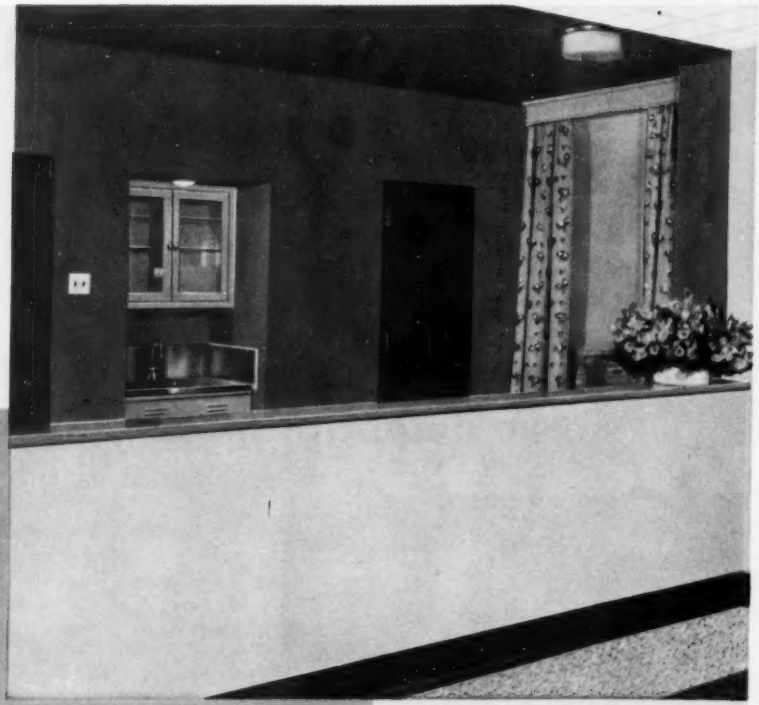
[2]Blumenauer, George: Moisture Problems and Control. Mod. Hosp. 76:114 (January) 1951.

ADDED INVESTMENT WORTH WHILE

Obsolescence is speeded in a project as its potential use diminishes or as its potential customers sense that better values are obtainable elsewhere. This is a simple truth which applies as surely in hospital service as it does in merchandising. The good usually costs more than the shoddy, but added capital investment, which will result in more efficient operation over the long term, usually is justifiable in hospitals.

6. Patients and Service. It seems important to plan the general hospital to meet the endemic needs of the community which it will serve. Not only are communities subject to changing conditions but the moderate and low-income groups of people greatly predominate in most communities. It seems consistent to be realistic in trying to shape the capital setup, orientation and gross yield of a hospital to what the patients or their sponsors can afford to pay for the hospital's cost and service in its community over the long term.

After all, it is our own ills of today which cause us concern and deplete our resources, not those of the next generation.



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Nursing Looks to Housekeeping for High Standards of Service

DOROTHY M. MORGAN, R.N.
Director of Nursing, University of Chicago Clinics
Assistant Professor of Nursing Education, University of Chicago

THEME of the housekeeping section of the Tri-State Hospital Assembly last month was "How Housekeeping Standards Will Benefit the Hospital." The discussion was opened by Mrs. Alta M. La Belle, consultant to the Veterans Administration, who spoke on the urgent need for establishing standards, followed by Emily C. Deming, Butterworth Hospital, Grand Rapids, Mich., and Mrs. Madge H. Sidney, Evanston Hospital, Evanston, Ill., who analyzed the problems of what procedures should be standardized and who should establish them. At the afternoon panel session, Miss Morgan discussed the point of view of the nursing department as to the need for housekeeping standards, which is presented this month. Mrs. Sidney's and Miss Deming's discussions will appear in succeeding issues of The MODERN HOSPITAL.—Ed.

THE professional nurse is primarily concerned with the restoration of the sick to health. This includes the promotion of health of both mind and body. It is her concern also to contribute to the prevention as well as to the cure of disease, to protect human beings from the injurious influences which menace health, and to improve the patient's environment so that it will be safer and more suitable for human living. Interpreted in terms of the hospital, this means that besides the giving of adequate nursing care to the patient, the professional nurse's interest is also to see that the environment which surrounds her patient is clean, safe and attractive. Thus the close cooperation of the nursing department with the housekeeping department is imperative if these objectives are to be achieved.

TWO DISTINCT AREAS

Within the history of nursing in hospitals, good housekeeping in the past has been both the concern and the duty of the nurse, and indeed today in hospitals, large and small, housekeeping duties are still carried on by the nursing department in greater or lesser degree. However, with the development of housekeeping as a science and an art, and with the growth of nursing as a profession, these two are now definitely separating into two distinct areas and each is undertaking those duties for which it is best trained and which it may best perform. With the development of the executive housekeeper, housekeeping is coming into its own both in hotels and hospitals as a department of considerable importance contributing in large part to the services of each.

In the total care of the patient, nursing looks to housekeeping for those values which it can contribute to the well-being of that patient. These may include the establishment and maintenance of the cleanliness of the hospital, the control of linen, and decoration of the hospital. Also, depending on the size of the maintenance department and on the policies of the hospital concerned, the duties of the housekeeping department in relation to the maintenance and repair of equipment may be great or small. Not the least of the duties of the housekeeping department are accident prevention and noise control.

The care and cleanliness of hospital interiors and equipment, valuable as they are today, must be in the hands of experts. Costly materials are being used in the construction of our hospitals and nothing but the best in equipment is being accepted. Correct methods of cleaning surfaces of all kinds—walls, floors, furniture and fixtures—mean increased longevity of these and the saving of hospital dollars. With the current increases in the average cost per patient per day in hospitals, every economy should be practiced. Poor upkeep means loss and waste. The good housekeeper knows the value of correct cleaning methods in preventing such waste.

Cleanliness contributes to the peace of mind of the patient and to the promotion of his sense of well-being. Most patients come from a clean environment, and even those who do not expect a hospital to be clean. Clean surroundings help to promote the confidence of the patient in the kind of care which he will receive. If his room is well cared for, he will have every faith that the medical and nursing care given him will be of high caliber.

LINEN PROBLEMS STUDIED

The problem of having a sufficient supply of linen at the bedside at the time when it is needed is being solved efficiently by many a hospital housekeeping department throughout the country today. Scientific studies are being made and have been made of the quality of linen needed to withstand hard hospital usage, and linen standards for hospitals are being set up. Methods of control of linens and linen distribution are being developed so that losses are being reduced and linen is available when and where needed. In relation to this, have *you* as a housekeeper set up a linen standard for your hospital nursing divisions, and do you have a sufficient linen inventory? If not, I will guarantee that hoarding and misuse of linen are in

Presented at the housekeeping section of the Tri-State Hospital Assembly, April 30, 1952.

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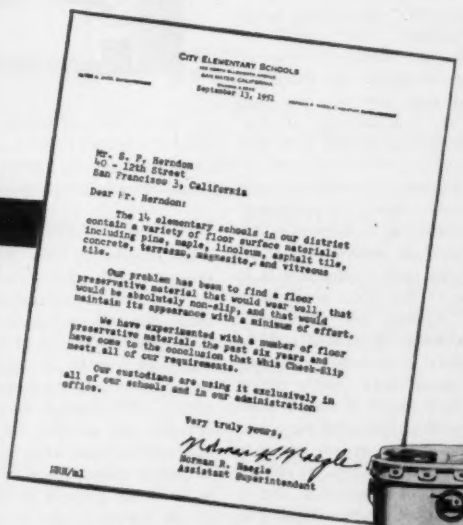

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September 13, 1951

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effect on these divisions. Where there is proper control of linen, patients do benefit. Clean linen, like clean surroundings, promotes serenity.

The fact that hospital housekeepers are being educated in methods of interior decoration is quite apparent in our attractive hospital interiors. Those of us who have been in hospital surroundings for a while have watched the progress of hospital color schemes from deadly all-white, through varying values of green, to utilitarian brown, until now the butterfly emerges from the chrysalis and our hospitals reflect the same good modern taste in decorations maintained in our own homes. The effect of color on the mental state of the patient has been a basis for many a scientific study. Hospitals are at last paying attention to the therapeutic effect of suitable color in the surroundings of the patient, and the patient is benefiting. Here again, then, housekeeping is definitely contributing to the welfare of those who are ill. How much a patient enjoys a pretty room!

BUT DON'T OVERDO IT

On the other hand, it is well to remember that interior decoration should not be overdone. I well recall the patient who was admitted to a room, the ceiling of which was painted a heavy steel grey, and who was sure that the "sky was falling!" Moderation in decoration should have first consideration.

In the matters of accident prevention and noise control, the housekeeping department has an important rôle to play also. A well-known insurance company once estimated that in an analysis of 463 guest accidents in hotels, 43 per cent were attributable to slips and falls. With early ambulation in effect in hospitals, obviously there are many more people out of bed in various stages of unsure walking. It therefore behooves the housekeeping department to pay attention to the kind of wax it uses, its method and frequency of application, and to see to it that all floor surfaces over which there may be traffic are kept free of standing water. A good housekeeping department will direct its workers to wash only one-half of a hallway at a time—*never* the full width of a hall surface at once.

With regard to the control of noise, all of us must work together toward that end. The blare of a radio, the sound of a loud voice, raucous laughter, the clang of a mop pail set down on a terrazzo floor, the banging of a door, the clatter of dishes being washed in a ward kitchen, the clank of metal utensils being dumped into the sterilizer in the utility room, are all too familiar noises which add to the distraction of an ill patient. Why cannot we provide our housekeeping service carts with noise reducing features? Speaking of service carts, could not someone produce a cart which would not bulk so large in a hospital hallway, and which would have at the same time greater utility and esthetic values? Surely the appearance of this useful equipment could be greatly improved.

Hospital service rooms for the housekeeping department need attention too. These should be so constructed that they are large enough so that the maid, when she is cleaning her mops and pails at the sink, will find it possible to close the door so as to block

out noise. It could be that the executive housekeeper as well as the director of nursing might serve as valuable consultants to the hospital architect!

KEEP THINGS IN REPAIR

In relation to how housekeeping can work with nursing in the maintenance of hospital equipment, there are many items of repair constantly needed in hospitals which housekeeping can and does remedy or delegate to the maintenance and engineering departments. We nurses, along with the patients, are grateful for equipment and surroundings kept in repair, for a broken down hospital reduces the faith of our patients in us. It is up to the nurses to see to it that need for repairs is reported to the proper department. Such things as leaking faucets, faulty call cords, burned out light bulbs, stained draperies, floors, walls, upholstered chairs, sticking venetian blinds, should all have prompt attention if a hospital is to appear as an efficient operating unit to the patient. Yet how often these things are neglected! Too frequently, the checking of these housekeeping duties is placed in the hands of the nurse whose primary objective is the nursing care of the patient, and whose interests in housekeeping details are of secondary importance to her.

With the increasing scarcity of nurses, housekeeping is being placed more and more in the area where it belongs—in the hands of our expert housekeepers. There are signs of it everywhere in the hospital scene, but nowhere is it more apparent than in the care of the patient's surroundings.

TAKING OVER NEW DUTIES

The trend in nursing today is to "render unto Caesar those things which are Caesar's"—that is, to give over to housekeeping those things which belong to housekeeping, and to relinquish duties which pertain to food and nourishment to the dietary department, and so on. Through the years, nursing has shown an overwillingness to help everyone in the hospital family until now in this period of nursing shortages it is feeling its burdens, and even if it would, it can no longer assume many of them. Already in many hospitals, housekeeping departments are taking over many duties formerly assumed by the nursing departments. These are:

1. Check-out service after the discharge of the patient.
2. Daily cleaning and sterilizing of wash and emesis basins and bedpans.
3. Care of patient's flowers.
4. Daily cleaning of patient's surroundings, including floors and furniture and general tidying of rooms and wards.
5. Cleaning of supply cupboards.
6. Daily cleaning of furniture and fixtures in the nurses' stations.
7. Kitchen cleaning, such as the cleaning of refrigerators.
8. Cleaning of equipment, such as intravenous stands and stretchers.

Ward helpers who have been doing such things under the direction of nursing departments are being trained to be aides and to give direct nursing care which is so badly needed.

Of course, every executive hospital housekeeper realizes that in order to maintain an effective functional department which will best serve her hospital, she must know and practice the principles of good administration. She must know how to plan for, to organize, staff and *direct* her department, and she must recognize the necessity not only of coordinating the

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activities within her department, but of coordinating her department's activities with those of other departments. She must also realize the importance of good records for her department, and have the ability to prepare and live by the department's budget. The functions of her department within the hospital, as has been pointed out, are rapidly changing these days, and because of this fact her ability to direct and teach those under her is not the least of her qualities as the executive of her department, if the work of the housekeeping department is to be carried on in an efficient manner.

Even though nursing is now giving up the actual performance of many housekeeping duties, it will probably always feel responsible for the cleanliness and safety of the patient's surroundings, and our preliminary students will therefore continue to be taught these things. On occasion they may actually have to care for a patient's surroundings, and it is well to be prepared. For those executive housekeepers who are attached to hospitals which have training schools, it is well to remember that standardized methods bring efficiency, and for the sake of standardization and continuity of method it is best to teach a housekeeping staff the same housekeeping procedures which are taught in the training school classroom. Day to day supervision of personnel on the job is also necessary if the procedures are to be carried out correctly. Adequate training and supervision are imperative wherever the housekeeping department assumes added duties.

U. OF C. USES VISUAL AIDS

In relation to this I would like to say that at the University of Chicago Clinics, as a teaching device, we are at present having colored slides made of various housekeeping procedures because we believe that visual education is most effective with the type of worker involved. It will take some time before we have the series completed, but good instruction is necessary if we are to have efficient workers.

There can be no doubt that housekeeping standards are benefiting and will continue to benefit the hospital. The executive housekeeper's work is becoming more extensive and more scientific every day. She has earned a position of importance on the scientific team, and her department takes its place along with all others.

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MHG-52

O.F. BALL: Baron Larrey

(*Continued From Page* 86)

Napoleon. In 1818 his pension was restored to him; in 1821 he was again made surgeon of the royal guard.

Accompanied by his son Hippolyte, who later held his father's position under Napoleon III, Larrey went to England to study the advancement made in medical science to be added to a work he was preparing on surgery. During the Revolution of 1830 he attended the wounded of both sides, carrying them to the hospital of Gros Caillou. Louis Phillipe decorated him with the "medal of July." The government then called him to the council of health of the French armies, and later an invitation of Belgium sent him to that country to organize its ambulance service. He was next appointed surgeon-in-chief of the Hôtel des Invalides. Then in his sixties, weakened bodily by the hardships he had endured, he was at the hospital at 6 o'clock each morning making rounds; then he gave clinical lectures and continued his writing.

With his son he went to Italy in 1834, stopping to visit the hospitals in each city. The next year he was sent to check the cholera epidemic in southern France. Because of an undefined dispute he left the staff of the Hôtel des Invalides; it is suggested that he was too ardent in his old love for Napoleon. When Napoleon's ashes were brought from St. Helena for burial, Dec. 15, 1840, Larrey stood in the cold, wearing his old uniform of the imperial guard and with bared head followed the cortege through the falling snow. The following year, with his son he inspected the military hospitals of Algiers. It was in the heat of the summer and he became fatigued but refused to rest because he wanted to see his sick wife and to make his report. He died at Lyons on July 24, two months after he had left for Algiers, unaware that his wife had just died. He was given a military funeral and his name was engraved upon the Arc de Triomphe with other illustrious names.

Napoleon said of his surgeon-in-chief in October 1816:

"What a brave and worthy man is Larrey! What care was given by him to the army in Egypt and everywhere! I have conceived for him the highest esteem. If the army were to raise a column to the memory of anyone, it should be to Larrey. He has left in my mind the idea of a truly honest man. He is truly a worthy man, for to science he unites all the virtue of an effective philanthropist. All the wounded are his family. The chief object of his consideration has been to exert himself in his hospital, in which he has been so successful as to entitle him to both my esteem and my gratitude."

In his will Napoleon left Larrey 100,000 francs, stating: "He is the most virtuous man I have ever known." A bronze statue by the noted sculptor David was erected in memory of Larrey in the court of honor of the military hospital of Val-de-Grace in Paris. In his uniform of military surgeon and wrapped in his cloak, Larrey stands with uncovered head, a manuscript pressed to his heart—the will of Napoleon. Near him are his books, his instruments and his arms. A cannon beside him bears the names of the principal battles in which he served. The greatest military surgeon, the builder of military hospitals, the great surgeon and philanthropist who dared every danger to save the life of friend or foe had joined the immortals.

"There is buried a soldier, a patriot; a great, learned and brilliant surgeon; a brave, truthful and loyal man; a gentleman and a benefactor of the human race."—Da Costa.

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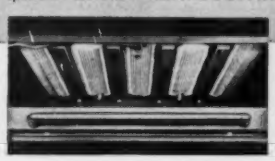

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President's Commission

(*Continued From Page 56*)

2. The second part of the tri-partite working plan, estimating the health needs of the American people, is now keeping us busy day and night. We have scheduled a series of more than 25 panels on every imaginable phase of medical care. Each of these panels is an all-day give-and-take session—no formal testimony and no ceremonial parading of witnesses. The country's 10 or 12 top experts in each of the fields sit down for a day behind closed doors and bat the problem around. The panel findings are then digested and presented to the full commission. By the time of the final panel somewhere around the last week in June, the commission will have heard several hundred top medical and lay experts from every section of the country give their off-the-cuff views on everything from promotion of health and prevention of disease to care of the mentally ill and the status of rural medicine.

Prior to these panels, the commission held a series of formal hearings on aid to medical education and local public health units. We heard 16 experts give fact-packed testimony which filled more than 500 pages of the commission's official records.

As a final step in estimating health needs, commission members are now mulling over the idea of a series of field trips to get a close, realistic view of both the good and bad in medical care today. As an example, there is talk of a trip to rural Mississippi to find out just what medical care rural people get. In addition to talking to people on the spot, the commissioners would visit country practitioners, look over local hospitals, study the state's regional medical plan, and so on. Another trip might take commissioners to a defense-impacted area where they could observe the many problems created for providers of medical care by sudden shifts of population.

3. Finally, when all the health resources have been inventoried, and all the needs have been ascertained, the commission will get down to the job of making its formal recommendations to the President, trying, as far as possible, to fit its final proposals within the framework of the achievable health resources of the country.

WORK SHOULD CONTINUE

Can we do the job of surveying the health needs of the nation in the brief year allotted to us? I don't think we can do an absolutely comprehensive job, but I think we will come forth with some solid facts and recommendations in December. However, there is feeling among some of the commissioners that this is really a five-year job which will change from year to year. If this commission is to be of any permanent value, it should be a continuing commission on the basis of the interest of the medical profession and the public to put all the information together that we can gather.

I have high hopes for this commission. In the past few years, there has been an excess of emotion and charges and counter-charges about this whole health problem. In this bitter dispute, the forgotten man has been the citizen in need of more and better medical care. If this commission can inject some light where too much heat has prevailed in the past, it will help signalize a desperately needed moving forward in bringing better medical care to all Americans.

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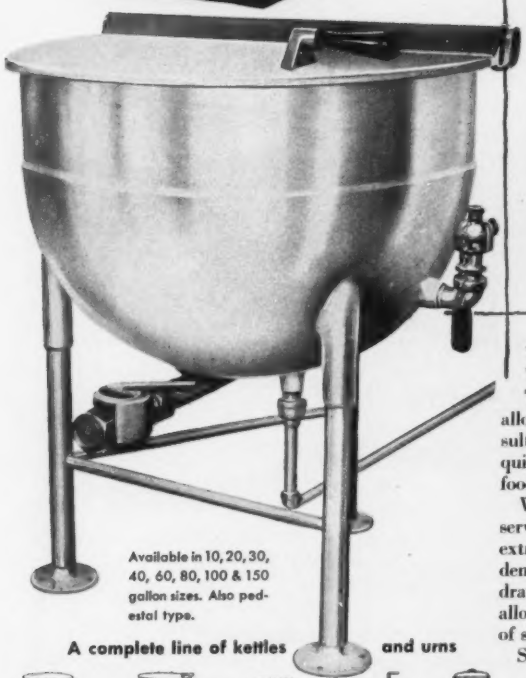

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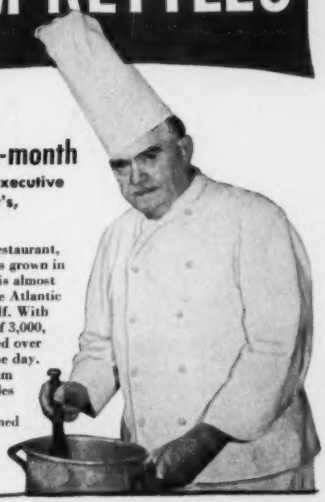

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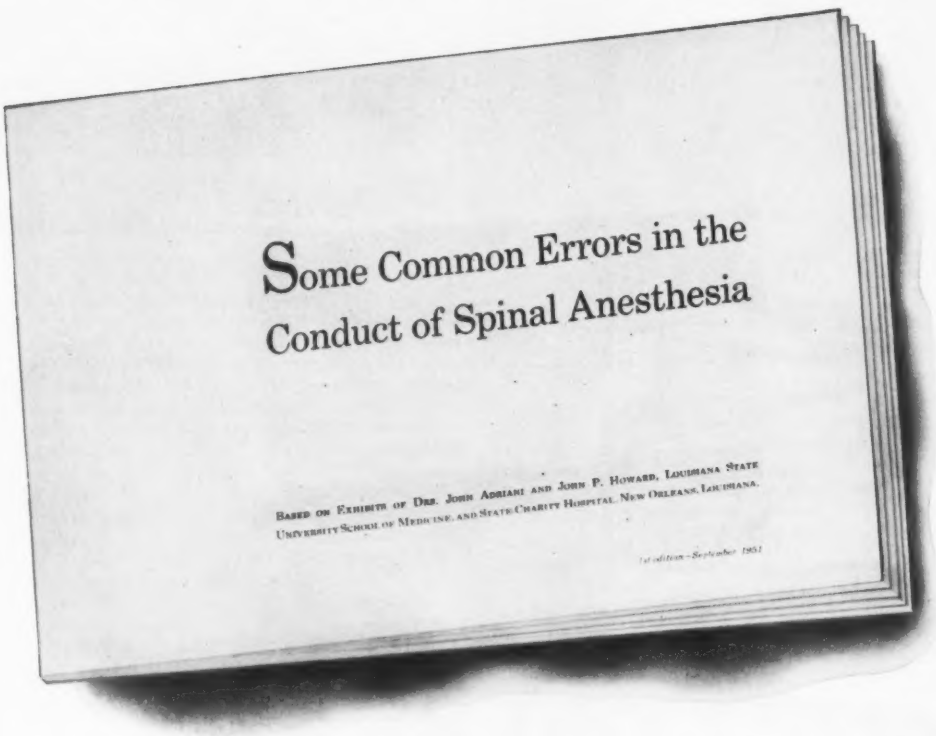

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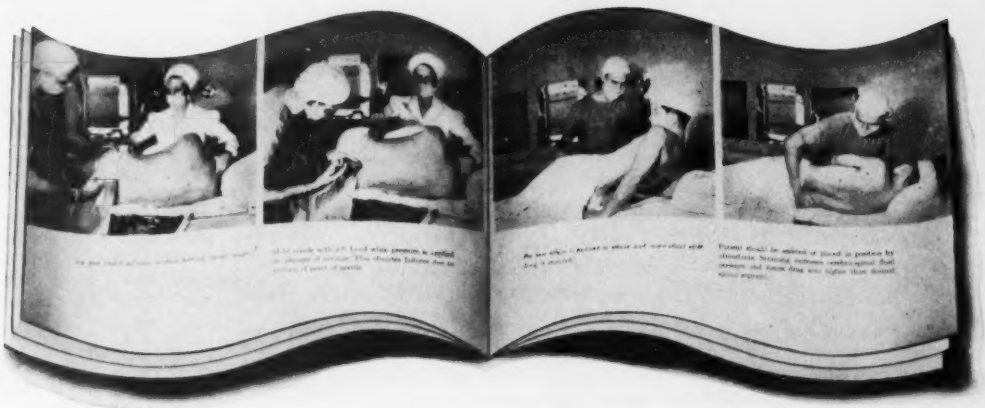

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NEWS DIGEST

Spring Roundup of Regional Meetings . . . Supreme Court Rules on "Trust" Case in Oregon . . . Finance Commission Launches Fact Finding Study . . . Universities Announce Residencies . . . Dr. Pratt Heads New York Association

3256 Representatives Set Record Attendance at Association of Western Hospitals Session

SAN FRANCISCO.—Smashing all previous attendance records, registration at the 22d annual convention of the Association of Western Hospitals here last month reached 3265 hospital representatives and guests from the eight states in the western association area and the Territory of Hawaii.

O. N. Booth, administrator of St. Francis Memorial Hospital here, was named president-elect of the association. He will succeed C. E. Wonnacott, Latter-Day Saints Hospital, Salt Lake City, Utah, who became president during the convention. Mr. Wonnacott succeeds Frank C. Gabriel of Albuquerque, N.M., retiring president.

Opening the first general session of the convention, George Bugbee, executive director of the American Hospital Association, reported increasing appreciation of the many skills and abilities required for effective hospital administration. Commenting on factors influencing hospital care throughout the nation, Mr. Bugbee said there was little likelihood that Congress this year would approve federal legislation on aid to nursing education. In a press conference for national hospital leaders attending the convention, Mr. Bugbee said the hospital field was "striving to achieve a balance, to avoid the dangers inherent in working with the government, yet accepting some support, such as in building hospitals, to be able to take care of all the people."

Following the opening address by Mr. Bugbee, Harry Becker, associate director of the Commission on Financing Hospital Care, predicted that the cost of hospital care would rise to an all-time high during the coming year and would continue to rise for several years more. "It does not follow, however, that the American people want to reduce the nation's hospital bill by demanding fewer services or a lower quality of care," Mr. Becker declared.

Higher expenditures for hospital service are no cause for alarm, Mr. Becker insisted. "The national policy of an expanding economy and our traditional American drive for continuously high standards of living call for increasing expenditures by the consuming public for all goods and services that contribute to individual and family well-being," he stated. "Higher expenditures for health services are the normal expectation and moreover are proper and appropriate."

OFFICERS OF WESTERN ASSOCIATION
Standing (l. to r.): D. L. Braskamp and John Sundberg. Seated (l. to r.): Richard Highsmith, O. N. Booth, Ralph Hromadka.

Constantly increasing hospital costs will present a problem of financing hospital care that can be met only through aggressive expansion of voluntary prepayment programs, Mr. Becker stated. Strengthening mechanisms for consumer financing of hospital care is one of two central aspects of the problem of hospital costs today, he concluded. The other aspect concerns increased productivity and efficiency in the use of hospital facilities and personnel, he said.

In the concluding address at the opening session, Chancellor Tully Knoles of the College of the Pacific, at Stockton, Calif., predicted that hospitals would remain in community hands and not be turned over to any government agency for operation. However, he warned, the government is not only willing but "increasingly more than willing" to take over education, health care and character building agencies where private means fail to support community enterprise adequately in these areas.

A second general session of the convention took up the subject of administrative and professional relationships from the standpoint of the medical staff, the administrator and the trustee. Speaking for the medical staff, Dr. Lewis A. Alesen of Los Angeles, president of the California Medical Association, said deficiencies in hospital nursing service might be met by more widespread use of auxiliary personnel and technicians in place of graduate nurses. To meet personnel problems arising in the hospital, Dr. Alesen said, doctors, adminis-

(*Continued on Page* 162)

Supreme Court Rules Against Justice Department in Oregon "Trust" Case

WASHINGTON, D.C.—In a 7 to 1 decision the U.S. Supreme Court ruled recently that the Justice Department had failed to prove its charges that a nonprofit medical and hospital insurance plan, sponsored by the Oregon State Medical Society, had violated the Sherman Antitrust Law.

The Justice Department alleged that the Oregon doctors had combined and conspired to restrain, and attempted to monopolize, the prepaid medical care field.

The decision, however, still leaves a number of important basic questions unanswered, according to William Holloway, head of the American Medical Association's bureau of legal medicine, since the Supreme Court merely held that the decision of the U.S. District Court in Portland was not "clearly erroneous" on the basis of the evidence presented. The Supreme Court, however, did not hold that the lower court had ruled correctly.

In an A.M.A. *Newsletter* Mr. Holloway stated that two unanswered questions are: Is the practice of medicine trade or commerce? Can the operation of a prepaid medical service plan constitute interstate commerce in any case?

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NEWS...

Growth of Blue Cross Cited by Mannix at Carolinas-Virginias Conference

ROANOKE, VA.—Blue Cross plans will ultimately cover 85 per cent of the nation's population, John R. Mannix, Blue Cross director of Cleveland, predicted in an address to the 22d annual Carolinas-Virginias Hospital Conference here last month. The conference brought together nearly 1200 representatives of hospitals in the four states, including affiliated groups of nurse anesthetists, dietitians, medical record librarians, and architects.

Mr. Mannix said Blue Cross had added an average of 10,000 members a day since 1945. "Probably nothing else ever offered the American people has had such rapid growth," he stated. Blue Cross has brought financial stability to hospitals, he said. "We're demonstrating that nonprofit Blue Cross plans make it possible to budget hospital care."

ARCHITECTURAL COMPETITION

One of the features of the conference was a hospital competition for architectural students sponsored by local chapters of the American Institute of Architects in cooperation with architectural schools in the area. Walter H. Simmons, an architectural student at Clemson College, was awarded first prize by the jury of hospital architects and administrators which studied dozens of plans submitted in the competition for design of a 100 bed hospital to serve a Southern community.

Other winners named by the competition jury were: Don S. Carpenter, University of Virginia, second prize, and William P. Brown, Virginia Polytechnic Institute, third prize.

Honorable mention awards went to Kenneth S. Connolly, M. Lindsey Hagood, and Roger B. Cotting, of Virginia Polytechnic Institute; Donald H. Roberts, and Nathaniel Gaines of Howard University, and Alvis O. George and Edward H. Shirley of North Carolina State College.

One of the principal addresses at the hospital conference was presented by O. R. Daughety, administrator of University Hospital at Augusta, Ga., who criticized hospitals for poor press relations policies.

"You can't kick a newspaper reporter in the teeth one day and expect him to give your hospital favorable publicity the next," Mr. Daughety stated. He urged administrators to be friendly and informative in dealing with newspaper representatives. Give newspapers all the facts, he suggested, and they will respect your confidence when necessary.

Architecture competition winners, l. to r.: Walter H. Simmons, first prize; Don S. Carpenter, second; William Phillips Brown, third.

Above all, Mr. Daughety urged administrators not to be evasive with newspaper reporters. This thought was endorsed by another speaker on the public relations conference, Dr. E. T. Thompson, regional officer of the U.S. Public Health Service, who told administrators to "lift the iron curtain" on what's going on in their hospitals.

J. Stanley Turk, administrator of the Ohio Valley General Hospital at Wheeling, W. Va., is secretary-treasurer of the conference. New officers named by the Hospital Association of West Virginia during the conference were: president, T. W. Patterson, administrator of Thomas Memorial Hospital at South Charleston; president-elect, W. O. Poling, Myers Clinic Hospital, Philippi, and vice president, H. P. Athey, Williamson Memorial Hospital, Williamson.

Charles W. Holmes Named President-Elect at 15th Southeastern Conference

ATLANTA, GA.—Charles W. Holmes, managing director of the Foundation Hospital at New Orleans, was named president-elect of the Southeastern Hospital Conference at the group's 15th annual assembly held here last month. Mr. Holmes will succeed Norman Losh, administrator of Orange Memorial Hospital at Orlando, Fla., who became president during the conference. Edwin B. Peel of Georgia Baptist Hospital here was the retiring president.

Registration at the assembly totaled 1363 hospital representatives—largest in the 15 year history of the conference. The group includes the state hospital associations of Alabama, Florida, Georgia, Louisiana, Mississippi, and Tennessee and embraces affiliated organizations of dietitians, medical record librarians, nurse anesthetists, pharmacists, and hospital auxiliaries.

The three-day assembly included discussions of current hospital problems and all phases of hospital operation. Guest speakers on the program included George Bugbee of the American Hospital Association; Graham Davis, director of the national Commission on Financing of Hospital Care; Dr. Anthony J. J. Rourke, A.H.A. president; E. I. Erickson, president of the American College of Hospital Administrators; Don E. Francke, president of the American Pharmaceutical Association, and James A. Hamilton, director of the hospital administration program at the University of Minnesota.

In addition to Mr. Holmes, other officers elected by the conference were vice president, John W. Gill, business manager of Mercy Hospital-Street Memorial at Vicksburg, Miss.; executive secretary and treasurer, D. O. McClusky, administrator of Druid City Hospital at Tuscaloosa, Ala. R. G. Ramsay Jr. of the Gartley-Ramsay Hospital at Memphis retired as executive secretary, an office he has held for the past several years.

V.A. Hospital Facilities Opened to Disaster Victims

WASHINGTON, D.C.—In keeping with its national policy of helping disaster-stricken areas to the full extent of its capabilities, Veterans Administration has come to the rescue of three communities threatened by flood and a polio epidemic.

At Fargo, N.D., the V.A. Hospital was opened for the 60 patients in nearby St. John's Hospital, a voluntary institution that was flooded by the Red River.

At Clinton, Iowa, the V.A. domiciliary institution outside the city was made available to the Red Cross for the care of families who were driven from their homes by the flooding Mississippi River.

The V.A. opened one floor of its recently completed hospital at Shreveport, La., for 338 polio victims of the city for whom the Shreveport Charity Hospital could not care because of the large number of cases.

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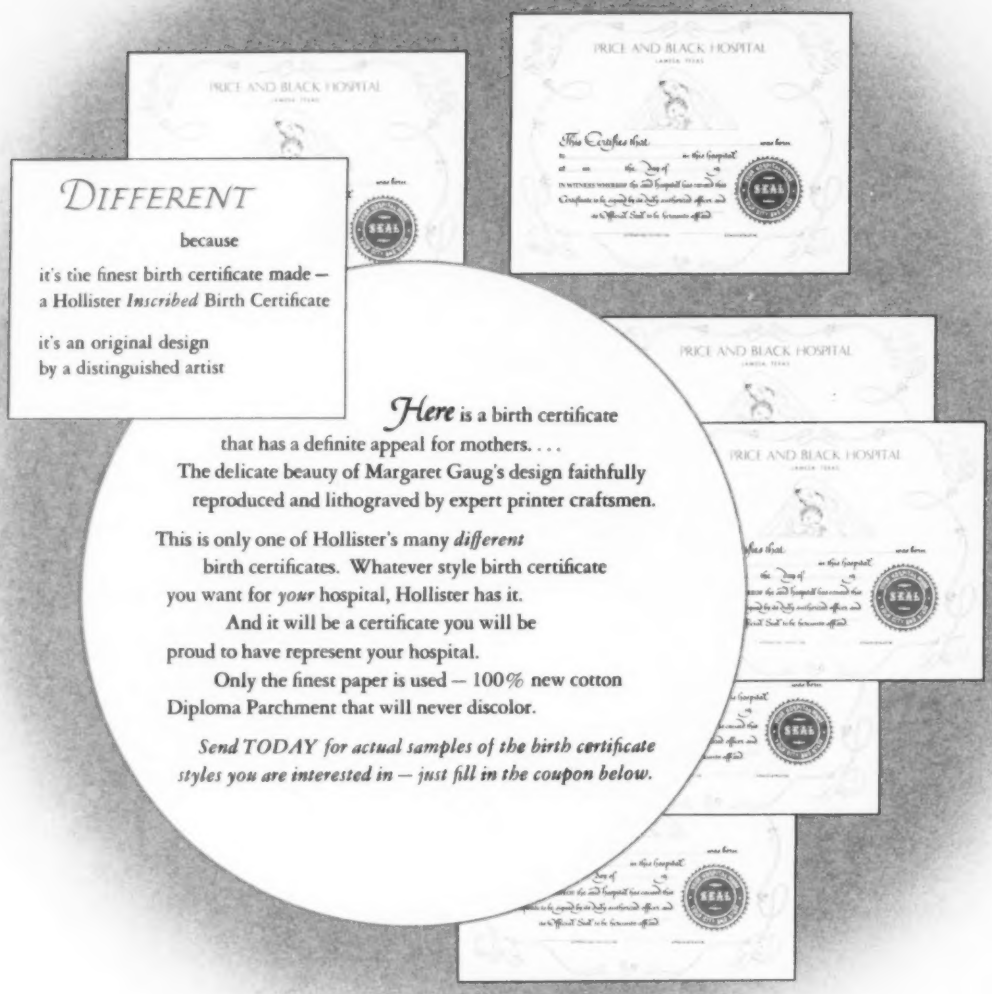

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NEWS...

Personnel, Trustees, Rehabilitation Hold Spotlight at Upper Midwest Conference

ST. PAUL.—More than 2700 hospital administrators, trustees, departmental executives and auxiliary members attended the fifth annual convention of the Upper Midwest Hospital Conference here last month. The conference included general sessions on chronic illness, control of medical care in the hospital, nursing, and hospital economics; section meetings were conducted for nurse anesthetists, dietitians, housekeepers, medical social workers, auxiliary members and others.

Speaking at a general session on hospital problems, Kenneth Williamson, executive secretary of the Health Information Foundation of New York, said the need for personnel is the major health problem confronting the people of the United States today. There are more than 400,000 career opportunities available in the health professions today, Mr. Williamson said, including vacancies for as many as 70,000 graduate nurses and 25,000 trained dietitians. As part of a nationwide campaign to bring these needs to the attention of the American people, Mr. Williamson said a committee of leading citizens should be formed to organize recruitment for the health professions, so that professional groups will not need to plead their own cause before the public.

Speaking at a session on board control of medical care in the hospital, Raymond P. Sloan, editorial director of The MODERN HOSPITAL and a hospital trustee, said most trustees assume the rôle of hospital policy maker or governor with "inadequate orientation, knowledge and background." What facts they do acquire, Mr. Sloan said, are "gleaned casually from the administrator and other authorities with whom they may come in contact."

In order to discharge their responsibilities effectively, hospital trustees must inform themselves, Mr. Sloan stated. The trustee should know what constitutes appropriate standing with such national bodies as the American Hospital Association, American Medical Association, American College of Surgeons, and the new Joint Commission on Hospital Accreditation, he stated. The trustee "should know what are the minimum requirements for sound operation, for providing adequate care of the sick, and for graduate training for interns and residents," he added.

Specifically, Mr. Sloan said, trustees must understand the importance of the medical audit, of medical records, the autopsy percentage, tissue committee, consultation ratio, and other professional indices.

Board action on staff deficiencies is indicated only when the staff itself does not meet its obligations of self-discipline and corrective action, Mr. Sloan emphasized. "Deficiencies are found in all walks of life," he concluded. "To deal with them successfully resolves into better understanding of one another's ideas, attitudes and functions."

During the conference, alumni of the course in hospital administration at the University of Minnesota held a luncheon meeting to discuss the value of organized alumni groups to the hospital administration student, the active administrator, and the hospital field as a whole. More than 40 University of Minnesota alumni and hospital leaders attended the luncheon and heard discussions by Mr. Sloan, Russell Nye of Northwestern Hospital, Minneapolis; Dr. Karl Klicka, St. Barnabas Hospital, Minneapolis; and James A. Hamilton, director of the university course.

THE NEXT BIG FIELD

Rehabilitation of the chronically ill will be the medical field's next big war on death and disease, Dr. Helen Knudsen, director of the division of hospital services, Minnesota Department of Health, stated at the session on this subject. "We must realize that men and women, regardless of age, are a part of our human resources and that we cannot afford to waste these resources," she said. "We must remember that chronic illness is the greatest single cause of dependency."

Dr. Knudsen said it was good, common-sense economy to wage an all-out war against chronic illnesses, the commonest of which are diseases of the heart and blood vessels, apoplexy, cancer, arthritis, diabetes and congenital malformations.

"From their earnings," she said, "rehabilitated persons who are employed for only 85 per cent of their life expectancy pay back in federal income taxes alone an estimated $10 for every dollar invested in their rehabilitation."

She cited the 59 bed chronic disease unit now under construction in St.

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John's Hospital, St. Paul, as an example of the trend toward facilities to fight chronic illness.

In another session, Dr. Edwin L. Crosby, director of the Johns Hopkins Hospital, Baltimore, and of the Joint Commission on Accreditation of Hospitals, talked on legislation on medical and hospital care for dependents of servicemen. "With more and more of our young men being called to service," he said, "the time is fast approaching when a majority of our population will be either servicemen, veterans or their dependents. If these groups are entitled to free medical and hospital care, we shall have accomplished socialized medicine without the necessity of specific legislation for it."

Finance Commission Starts Fact Finding Phase of Two-Year Nationwide Study

CHICAGO.—Detailed proposals relating to emphasis, organization and methods of study were approved by the Commission on Financing of Hospital Care when it launched the fact finding phase of its two-year national study April 19 in Washington, D.C.

In order to avoid any duplication of projects by other agencies in its fact finding projects, the commission is now conducting a careful survey of all research being made in the field of hospital care financing.

At the April 19 meeting the commission elected to devote a major portion of its budget and staff resources to intensive study of the following basic problems:

1. Evaluation of the current financial position of hospitals and a determination of hospital cost elements and the factors that affect these elements, including identification of cost and methods of financing medical research and professional education.

2. Physician-hospital relationships and varying patterns of medical practice as they affect the cost of hospital care.

3. Financing of hospital care for the nonwage, low income, rural and chronic illness groups.

4. Problems associated with voluntary prepayment of hospital care, including methods for determining amounts of payments to hospitals by prepayment and other agencies buying care.

To advise on the development of research projects for each of the basic

studies, special committees composed of commission members have been established. The commission also is appointing advisory committees of experts in the fields of statistics, prepayment, fiscal studies, and effects of varying patterns of medical practice on hospital costs. Consultants on problems of chronic illness, community organization, industrial management and economics are being engaged.

An intensive study will be made by the commission in the field of hospital financing problems. A group of selected communities will be chosen on the basis of such factors as the extent of local cooperation and local financing that can be obtained and the availability of study material.

Methods for coordinating community hospital facilities, improving administrative methods in hospital operation, financing hospital care for the chronically ill, and determining economic limitations in expansion of hospital services also will be studied by the commission.

Although the national studies will be directed to 10 specific subjects that appeared to the technical advisory committee to be the ones of primary significance, the studies undertaken by the commission will cover only the previously mentioned four basic problem areas. The 10 subjects are:

1. Problems associated with extending and strengthening our system of voluntary prepayment of hospital care.
2. Physician-hospital relationships, including such problems as the relationship of varying medical staff patterns to the cost of hospital care.
3. "Third-party" payments, including the best methods for determining amount of payments to hospitals and the relationship of "third-party" agencies to the hospitals and the public.
4. Community planning as a mechanism to achieve an integrated pattern of community hospital services and facilities, including study of the process of community planning.
5. Financing of hospital care for the nonwage, low income, rural and chronic illness groups.
6. Determination of the elements of hospital cost, the factors affecting the elements of cost, and the relationship of actual cost to charges.
7. Economic and other limitations for society and the individual affecting ability to pay for and provide continued expansion of hospital services.
8. Methods of financing and providing care for the chronically ill.
9. Possible reduction of hospital costs through improved management practices and through development of such facilities and services as outpatient and home care programs.
10. Financing of medical research and professional education and their relation to the cost of providing hospital care.

Dayton Has Hospital Council

DAYTON, OHIO.—The Dayton Hospital Council was formed here recently by three hospitals to solve common problems and provide better service for patients.

Dr. Frank C. Sutton, administrator of the Miami Valley Hospital, is chairman, and Charles Goff, the hospital's administrative assistant, is the secretary.

Sister Cyril, administrator of Good Samaritan Hospital, Sister Bathildis, administrator of St. Elizabeth Hospital, and Dr. Sutton comprise the council.

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Tri-State Hospital Assembly Report

(*Continued From Page 65*)

Mich., said, echoing what Mrs. Jac Ochiltree of St. Charles, Ill., told a meeting of hospital public relations directors. "Give us the facts and let us go," Mrs. Ochiltree urged.

This goes for employes as well as auxiliary members, Robert Newcomb, a Chicago public relations counselor, told the public relations conference. Speaking on the house organ as a means of communication between employer and employes, he warned against the kind of employe paper that is a one-edged propaganda tool for management. "You tell your employes they're on the team, so let them in on the signals," he stated, describing the house organ, in terms that Earl Planty would have heartily approved, as a "handshake by mail."

In another Tri-State meeting, better public relations and human relations were seen as answers to one of the gravest economic problems facing the voluntary hospital system today, abuse of Blue Cross benefits. Speaking carefully but with unmistakable force and feeling, Dr. Kenneth Babcock told a joint conference of Blue Cross executives and hospital administrators that all four groups — physicians, patients, hospitals and Blue Cross—were guilty. Like a prosecuting attorney building a case before a jury, he enumerated the evidence: Doctors, he said, were hospitalizing Blue Cross patients unnecessarily and keeping them in the hospital too long (examples: 45 hospital days for a hemorrhoid case, an ulcer patient whose doctor ordered a telephone installed for business purposes and let the patient go downtown for business conferences); ordering unnecessary medications and laboratory tests. Hospitals were failing to investigate and control abuses, permitting delays and bottlenecks in diagnostic workups, postponing discharges because of slow reports on tests, failing to check on routine orders, and permitting large "go home prescriptions" for Blue Cross members, Dr. Babcock charged. Patients themselves were "getting the works" when hospitalized for illnesses not requiring extensive diagnostic service, staying in the hospital for social rather than medical reasons, and taking the attitude that Blue Cross is fair game for exploitation. Finally, Dr. Babcock accused Blue Cross

of trying to carry water on both shoulders—advertising to the public that the complete hospital bill would be paid, then enforcing "fine print" restrictions on hospitalized patients.

What is needed, Dr. Babcock concluded, is restatement of the basic Blue Cross principle of paying for care of critical illness, and not paying for diagnostic services. He urged hospital administrators and Blue Cross executives to organize systematic programs of education for medical staffs and the public, looking toward elimination of abuses. In a lively discussion period that followed his address, he defended the proposition that hospital administrators, and not doctors alone, must accept responsibility for control of Blue Cross utilization. Too many administrators take the attitude, "Who am I to criticize the staff for these abuses?" he said. "It is your duty to get a staff committee to investigate and act," he told the group.

In other conferences, hospital administrators and departmental executives brooded with one another about their problems of accounting, purchasing, housekeeping, record keeping, engineering, building, furnishing, training, feeding, hiring, firing and living together from day to day—the myriad duties and responsibilities that add up to what Earl Planty called "the business of being boss." Going home at the end of the third day with aching feet and buzzing heads, hospital bosses remembered Rollin Posey's admonition: "An administrator can get no more effective performance than he is able to deliver personally; the way he does his own work is an inspiration to everybody else."

Mid-West Hospital Association Report

(*Continued From Page 66*)

shillelagh, he warned: "The problems of one group are the problems of the other; economic welfare is not just an administrative problem, it is a problem of all members of the staff."

Professor Houston pursued much the same line of reasoning, but in a lower key, in his Thursday morning talk. "In order to give good service to people, it is very probable the staff should be interested in people," Professor Houston understated. The problem, he believes, is to develop not aptitudes but the right attitudes.

How to go about this? First, management must have a good attitude toward workers. One person can affect the emotional climate of the whole hospital for good or ill. If the administrator talks "discipline," instead of "development," the organization will be oriented to discipline. Second, the administrator must work by precept and example. The shout-and-scare-'em school of leadership is dead. The administrator must develop power *with* people—not over people. Today, leadership is personal.

Professor Houston deplored the American tendency to be what he called "so confoundedly property-conscious." He considers that good morale among the employes is a lot more important to the patients than a brand new building and glittering equipment.

Leadership in the person of the administrator came in for a curry-combing at the hands of Ray Brown, whose talk on "Warning Signs of Administrative Failure" gave his hearers cause for some intensive soul-searching. "The

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man who gets fired or quits isn't the only one who is a failure," he reminded them. "Many administrators fail day by day over a long period."

An administrator's job, as Mr. Brown sees it, is first to represent the hospital; second, to make decisions; third, to arrange resources, and, fourth, to evaluate the organization, to determine what is going on, and whether the right thing is being done at all times.

Up to this point the audience nodded in happy agreement. The glazed look that betokens the eye turned inward appeared as Mr. Brown enumerated a few symptoms of failure. Heading the list was failure to establish two-way communication, upward between the administration and the board of trustees, and downward between administration and employes. The next two symptoms are just opposite sides of the same coin. On the one side is the administrator who insists upon trying to find "perfect" solutions at once instead of being satisfied with gradual progress. On the other side is the fellow who refuses to take a stand when a principle is involved and "buys" his way out of difficult situations. This type of administrator, Mr. Brown estimates, changes jobs about every five years—the time it takes for his tactics to catch up with him.

An obsession to win every argument, failure to share credit with employes and fellow workers, and failure to maintain "the elbow-room of impersonality" were other symptoms mentioned. A pinkish glow was visible on several faces when the subject of impersonality came up. Mr. Brown takes an acid view of the administrator who prides himself on his cozy relations with his help. "If you want the elevator boy to call you Ray," he said, "go ahead and call him Joe." Friendliness, in Mr. Brown's language, is not to be confused with familiarity.

While the administrators were searching their souls, the auxiliaries were searching for ways to make money and otherwise make themselves of real value to their hospitals. The ways they find are numerous and profitable, and small town auxiliaries are as resourceful as their metropolitan sisters.

Witness Mrs. W. L. Gatz, president of the Woman's Auxiliary, Community Methodist Hospital, Paragould, Ark. (Pop. 9000). Mrs. Gatz and her auxiliary were embarrassed to discover in July 1950 that the shiny new hospital

they had helped to create was opening with a $17,000 deficit and very few patients. Feeling that this was no way to treat their new administrator, the women went to work to change both situations. How they did it was explained by Mrs. Gatz in a breath-taking recital of the social and civic activities that set Paragould on its ear and netted the hospital $14,000 in eight months. But the greatest contribution, Mrs. Gatz feels, is the understanding of the hospital's needs that has been aroused.

Concluding her talk, Mrs. Gatz endeared herself to every administrator in the room by stating flatly: "An auxiliary president has many duties; trying to run the hospital is NOT one of them."

The fireworks that had been anticipated from the "Town Meeting" debate over the effect of the Veterans Administration's hospital program on voluntary hospitals never materialized. It was Friday afternoon and the few remaining delegates were suffering from Third-Day-of-Convention-Itis. They just didn't have enough energy to get mad.

Gerhard Hartman of the University of Iowa Hospitals and Dr. Robert C. Cook, suave representative of the Veterans Administration, didn't get mad either. They conducted their debate on a high plane of politeness and mutual regard. Noted as being a handy man with a harpoon when he chooses to wield it, Mr. Hartman in this case elected to discard the harpoon in favor of statistics. He based his talk on the answers received from 36 hospitals of all sizes and types to two questions: (1) Have you lost any employes to the Veterans Administration hospital in your community? (2) Have you had to increase salaries and pass the cost along in the form of raises in rates?

In essence, the replies indicated that the presence of V.A. hospitals, with their higher salary scale and the security offered by civil service rating, constitute a continuous threat to voluntary hospitals. Several replied that they had already lost both nurses and nonprofessional employes to the V.A.; that they had had to raise salaries to meet the competition, and that they had been forced to raise rates. Others have not yet felt the pinch but expect to shortly. One of the big difficulties seems to be the general feeling of unrest created among voluntary hospital employes by the presence of the V.A. hospital across the street.

Reporting for his own institution, Mr. Hartman stated that 40 nonprofessional employes had left the University of Iowa Hospital to go to the V.A. Thus far, he has not lost many nurses and the situation generally has not been serious. Unquestionably, however, the labor market in Iowa City is tightening, he added.

In his turn Dr. Cook pointed out that the V.A. is having a little staffing trouble of its own. Many beds in veterans' hospitals remain closed for lack of personnel. And, much as Dr. Cook regrets the fact, the law of the land says that the V.A. cannot refuse an applicant for employment just because he is already employed in a civilian hospital. If he has the necessary qualifications, he must be hired. Wherever possible, V.A. hospital officials try to soften the blow by delaying the acceptance of an employe's application until the voluntary hospital has at least had a chance to replace him, the speaker stated.

As to the higher salaries, Dr. Cook explained that the wage scale of civil

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service employes must be uniform across the country, and although it admittedly works a hardship on some communities, in others, government hospital salaries are no higher than those found in voluntary hospitals, and sometimes are not even as high.

Politely but firmly, Dr. Cook declared that the V.A. has a mandate to give the best possible care to veterans, and in pursuit of that objective, it proposes to attract the highest possible quality of personnel.

In a harmonious duet Mr. Hartman and Dr. Cook reminded their audience that the Veterans Administration is the servant of Congress, which in turn is the servant of the people—present company included. It is up to the voluntary hospitals, they agreed, through their state and national associations to educate Congress. How badly Congress needs educating, Mr. Hartman pointed out, is evidenced by the fact that it fires some 6200 employes with one hand and builds new hospitals that cannot be staffed with the other. Congress must be told to arrest the building program and make proper use of existing facilities, he concluded.

H. J. Mohler, president-elect of the association, who conducted the meeting, obviously felt that not nearly enough had been said about the dangers of the V.A. expansion program. The problem is not simply one of competition for employes or increased salaries and rates, he declared. Veterans and their families now constitute 33 per cent of the population; by 1955 that figure will be up to 40 per cent. If this goes on, Mr. Mohler reasoned dismally, pretty soon there won't be any need for voluntary hospitals. The Veterans Administration will just take over.

Although a majority of the audience undoubtedly agreed wholeheartedly with Mr. Mohler's view, at that point nobody cared enough to do anything about it. So the 1952 meeting of the Mid-West Hospital Association adjourned—to take up again April 15 to 17, 1953.

Doctors Stay on Staff

POUGHKEEPSIE, N.Y.—St. Francis Hospital here, which last January 31 ordered seven non-Catholic physicians on its staff either to sever their connections with the Dutchess County League for Planned Parenthood or resign from the hospital, still maintains all seven staff physicians, even though four are still associated with the league.

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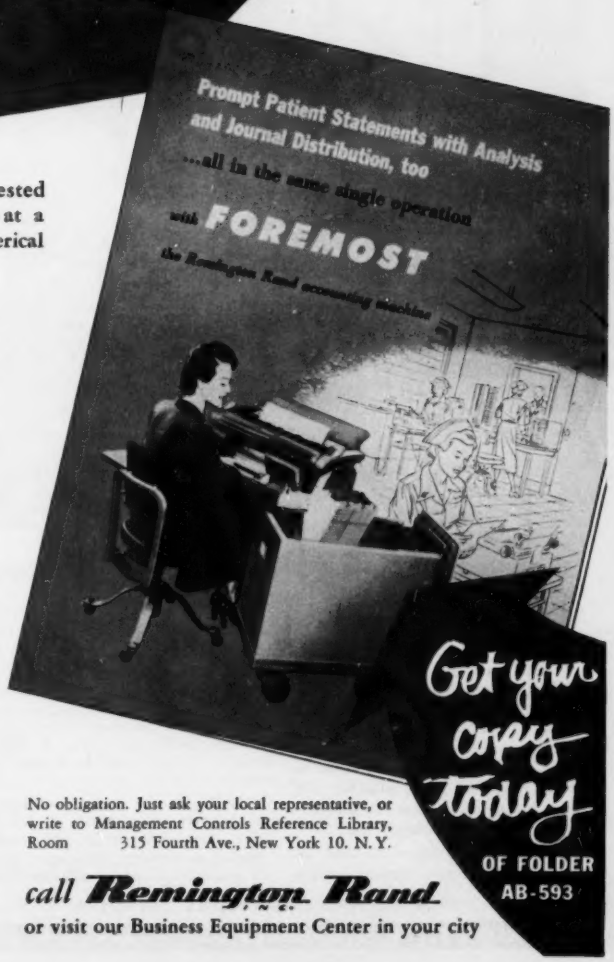

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Record Attendance at Western Hospitals Meeting

(*Continued From Page* 142)

trators and others must cooperate to make nonprofessional workers feel their work is just as important as that of professional people in charge of actual patient care. Nevertheless, he warned that increasing use of nonprofessional people in the hospital might make hospital employes more easily subject to organization by labor unions. Dr. Alesen acknowledged that staff doctors could help effect hospital economies by changed attitudes and better planning of their own work.

Criticizing the unnecessary severity of medical records regulations, Dr. Alesen described the medical record librarian as a "new type of medical aristocrat" who insists on too many technicalities and wastes too much of the doctor's time. The purpose of medical records is to provide the necessary information for proper patient care and to give both patient and doctor adequate legal protection, he said. Beyond these minimum requirements, he indicated, a great many presently required records procedures could be eliminated without loss. Dr. Alesen urged hospital administrators to study management engineering methods used in industry and apply modern procedures wherever possible in hospital operation.

Speaking for the administrator, Dr. Anthony J. J. Rourke, president of the American Hospital Association, said the administrator today suffers from "multiphasic bossing." The administrator is subject to pressure from many different groups, Dr. Rourke stated—"including associations," he added. As a part of the problem of staff-administrator relations, he said, there is too much competition between the administrator and the members of the medical staff for the favor of hospital trustees. "We must develop friendship between staff doctors and administrator," he stated.

Speaking from the trustee's point of view, the Rev. Donald A. MacGowan of Washington, D.C., said hospital people spend too much time looking at and envying other hospitals and not enough time studying their own hospitals. He echoed Dr. Rourke's appeal for better understanding of one another's problems. "We all want to be respected, wanted and loved," Father McGowan concluded. "But remember, the hospital patient wants all these things—in technicolor!"

In another general assembly, Rollen Waterson, executive secretary of the Alameda-Contra Costa Medical Association, said the doctor's principal problem in getting along with people emerged from an assumption of superiority over his fellow men. He described studies made by Dr. Ernest Dichter, psychological consultant, which revealed that most doctors chose their profession for idealistic reasons but failed to get public appreciation because "so many have been misled by something incorrect in their teaching to believe that becoming a doctor should make them different from other people. They aren't."

As a result of the Dichter studies Mr. Waterson reported, doctors have been urged to treat their patients as intelligent equals able to understand the nature of their diseases. "Then we know they'll get appreciation, even when they fail," he stated.

Mr. Waterson said a public relations program based on the psychological findings had already paid off in a better doctor-patient relationship in the East

Bay area. The principle behind the Alameda County program is a simple one, Mr. Waterson stated: "Medical care being a necessity of life upon which doctors hold a monopoly, the medical society has broad public responsibilities in this area."

The final general session took up the subject of management and industrial relations in the hospital. Speaking at this session, Howard Kaltenborn of the Institute of Industrial Relations at the University of California, Berkeley, said management must make employes understand the reasons for authority and discipline and the advantages for workers of following planned, disciplined routines. Workers must be physically and mentally capable of complying with planned discipline, he added, and must understand that regulations are consistent with the over-all purpose of the organization. Most people work best when they are working toward goals which they understand and believe, Mr. Kaltenborn stated.

In another industrial relations talk, George L. Hall of the Standard Oil Company of California said a common error in administration is permitting the worker to have more than one boss. This can be avoided only through proper organizational structure, Mr. Hall said. The structure should be fixed, he added, but it need not be inflexible.

In addition to Mr. Booth, other officers named by the association were: first vice president, Ralph Hromadka, administrator, Santa Monica Hospital; second vice president, D. L. Brascamp, administrator of the Alhambra Community Hospital; third vice president, John L. Sundberg, administrator of the Caldwell Memorial Hospital, Caldwell, Idaho; treasurer, Richard Highsmith of the Children's Hospital of the East Bay, Oakland.

Meeting concurrently with administrators in planned section programs were groups of accountants and administrative assistants, nurses, auxiliaries, chaplains, dietitians, housekeepers, laundrymen, medical record librarians, social workers, nurse anesthetists, pharmacists, and administrative interns and residents.

St. Louis University Plans Three Nursing Institutes

ST. LOUIS.—The following program of special institutes will be offered this summer by the school of nursing at St. Louis University here:

Institute in Nursing Service Administration, June 30 to July 11; Institute on Venereal Disease Nursing, June 2 to June 13, and Institute on Cancer Nursing, July 28 to August 8.

A practical workshop in nursing service administration, designed to help those who wish to work out administrative problems pertinent to their own area of specialization, will be held from July 14 to 25.

In cooperation with the staff of the Catholic Hospital Association, the university's department of hospital administration will offer an Institute on Hospital Administration. It is designed for hospital administrators who will not have an opportunity to acquire a graduate degree in their field. The program is divided into three separate courses: introduction to hospital administration, June 17 to July 5; hospital accounting, July 7 to July 12, and problems in hospital finances, July 14 to July 19. Each course carries two hours of academic credit.

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Administrative Residencies Assigned to N.U. Students

EVANSTON, ILL.—Twenty-three students in the program in hospital administration, who finished their academic work at Northwestern University in June, were appointed to the following administrative residencies:

Arthur Allaben, Wesley Memorial Hospital, Chicago; William B. Barnhart, Harrisburg Polyclinic Hospital, Harrisburg, Pa.; Eugene G. Boyd, Baptist Memorial Hospital, Memphis, Tenn.; William B. Calvin, Passavant Memorial Hospital, Chicago; Joseph M. DeFilippo, Fitkin Memorial Hospital, Neptune, N.J.; John Cheney Ellerbe, Orange Memorial Hospital, Orlando, Fla.

William K. Hegarty, California Hospital, Los Angeles; James H. Henderson, Presbyterian Hospital, Denver; Edward F. Hunter, Geisinger Memorial Hospital, Danville, Pa.; C. Lindley Jackson, Colorado General Hospital, University of Colorado Hospitals, Denver; Thomas Ray Jones, Methodist Hospital, Memphis, Tenn.; Robert J. Lawrence, Herrick Memorial Hospital, Berkeley, Calif.; Marcel J. U. Letendre, New England Center Hospital, Boston; C. Willard Lewis Jr., Hermann Hospital, Texas Medical Center, Houston, Tex.; Judson F. Marsters, Medical Center Hospital, East Texas Medical Foundation, Tyler, Tex.

Robert P. Mathieu, Worcester City Hospital, Worcester, Mass.; David W. Morgan, Lloyd Noland Hospital, Fairfield, Ala.; Robert E. Moss, Memorial Hospital of Sandusky County, Fremont, Ohio; Stanley K. Read, Maine General Hospital, Portland, Me.; Paul R. Reese, Freedmen's Hospital, Washington, D.C.; Michael Rodzenko, Malden Hospital, Malden, Mass.; Richard G. Shedd, Santa Barbara Cottage Hospital, Santa Barbara, Calif., and Philip L. Wisdom, Mansfield General Hospital, Mansfield, Ohio.

Association of University Programs Holds Meeting

SAN ANTONIO, TEX. — Representatives of the 11 member institutions of the Association of University Programs in Hospital Administration attended a meeting here April 18 and 19 in the headquarters of the Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston. During the course of the meetings, two additional members were voted into the association. These were the Army Medical Field Service School of Hospital Administration here, which is affiliated with Baylor University, and the program at the University of Iowa.

James A. Hamilton, director of the University of Minnesota hospital program, and Dr. Herluf V. Olson, formerly dean of the Tuck School of Business Administration at Dartmouth University and now director of the association's new commission to study all hospital graduate programs, presented an outline of the proposed survey, which will be financed by the W. K. Kellogg Foundation.

Dr. Arthur C. Bachmeyer, a pioneer in graduate educational programs for hospital administration, was honored in absentia by the presentation of a special scroll designed for him. Dean Conley, executive secretary of the American College of Hospital Administrators, reported progress in revision of the administrative residency training manual. Delegates at the meeting discussed the term "administrative resident," and after considering various

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angles of this terminology, decided to retain this designation rather than revert to the term "administrative intern" or adopt some other way of designating students during their active hospital training program.

Dr. Leonard Bradley, executive secretary of the Canadian Hospital Council and director of the University of Toronto's program in hospital administration, presented a report on the correspondence extension course now in operation in Canada for hospital personnel.

Columbia Announces Residency Appointments

NEW YORK.—Columbia University's School of Public Health has announced the following administrative residency assignments for its students, who have completed their academic requirements in the program in hospital administration:

Dr. Julio Arango, Lebanon Hospital, New York City; Miguel Arrieta, San Patricio Veterans Administration Center, San Juan, Puerto Rico; Frank Bassong, St. Barnabas Hospital, Newark, N.J.; Louise Cavagnaro, University of Virginia Hospital, Charlottesville; Howard Claus, Hurley Hospital, Flint, Mich.; Francis M. Coe, Ellis Hospital, Schenectady, N.Y.; Jack Cole, University Hospital, Baltimore, Md.; Josue Colon, San Patricio Veterans Administration Center, San Juan, Puerto Rico; Thomas Dailey, Staten Island Hospital, Staten Island, N.Y.; William Derevlany, New York Hospital, New York City; David Everhart, Ford Hospital, Detroit; Norman Finer, Beth Israel Hospital, Boston; Dr. Martin L. Guzman, Massachusetts General Hospital, Boston; Robert Haith Jr., Freedmen's Hospital, Washington, D.C.; Richard Hinds, University Hospital, Ann Arbor, Mich.; Harold Horrocks, East Orange General Hospital, East Orange, N.J.; Nick Karabaich, Springfield Hospital, Springfield, Mass.; Sally Knapp, Syracuse Memorial Hospital, Syracuse, N.Y.; Dr. Marcel Lapointe, Beth Israel Hospital, New York City; Roland Levert, Royal Victoria Hospital, Montreal, Que.; Kenneth Meredith, Muhlenberg Hospital, Plainfield, N.J.; J. Paul Morris, Hospital of the University of Pennsylvania, Philadelphia; William Mylchreest, Grace Hospital, Detroit; Carl Mosher, Strong Memorial Hospital, Rochester, N.Y.; Leon Niemiec, Jackson Memorial Hospital, Miami, Fla.; Banks I. Paul, Kennedy Hospital, Memphis, Tenn.; Joseph Rose, Harper Hospital, Detroit; G. Dale Splitstone, University of Colorado, Denver; Eugene Tillock, U.S. Marine Hospital, Staten Island, N.Y., and Charles Womer, Lakeside Hospital, Cleveland.

Dr. Pratt Heads New York Hospital Association

NEW YORK.—Dr. Henry N. Pratt, director of the Society of the New York Hospital here, was installed May 14 as president of the Greater New York Hospital Association at the association's annual dinner. Dr. Pratt succeeded Fred Heffinger, superintendent of Manhattan Eye, Ear and Throat Hospital.

The association is a nonprofit organization representing 93 voluntary nonprofit hospitals and 30 municipal hospitals in the New York area.

Other officers installed were: president-elect, Dr. A. P. Merrill, superintendent of St. Barnabas Hospital for Chronic Diseases; vice president, Dr. Martin R. Steinberg, director, Mount Sinai Hospital; treasurer, Louis Miller, director of Jewish Memorial Hospital;

Chef Marvin Taylor at the Gas range. 1000 meals a day are served to staff and patients at Arlington Community Hospital, North Arlington, Va.

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secretary, Fred K. Fish, director of Lutheran Hospital of Brooklyn; executive director, Dr. John V. Connorton, and counsel, Emanuel Hayt.

Newly elected members of the board of governors are: Dr. Madison B. Brown, executive vice president, Roosevelt Hospital; Dr. Lloyd H. Gaston, executive director, St. Luke's Hospital; John S. Parke, executive vice president, Presbyterian Hospital; Louis Schenkweiler, superintendent, Wyckoff Heights Hospital; and Dr. Anthony J. J. Rourke, executive director, Hospital Council of Greater New York.

COMING MEETINGS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Shoreham Hotel, Washington, D.C., Oct. 13-17.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Benjamin Franklin Hotel, Philadelphia, Sept. 14, 15.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Fellows' Seminar, University of Michigan, Ann Arbor, Dec. 5-8.

AMERICAN DIETETIC ASSOCIATION, Municipal Auditorium, Minneapolis, Oct. 21-24.

AMERICAN HOSPITAL ASSOCIATION, Philadelphia, Sept. 15-18.

AMERICAN MEDICAL ASSOCIATION, Palmer House, Chicago, June 9-13.

AMERICAN NURSES ASSOCIATION, Atlantic City, N. J., June 16-20.

AMERICAN PHYSICAL THERAPY ASSOCIATION, Bellevue-Stratford Hotel, Philadelphia, June 23-28.

BRITISH COLUMBIA HOSPITAL ASSOCIATION, University of British Columbia, Vancouver, June 16-20.

COLORADO HOSPITAL ASSOCIATION, Denver, Nov. 6, 7.

ILLINOIS HOSPITAL ASSOCIATION, Abraham Lincoln Hotel, Springfield, Nov. 20, 21.

INDIANA HOSPITAL ASSOCIATION, Hotel Lincoln, Indianapolis, June 13.

INSTITUTE OF HOSPITAL ACCOUNTING, AMERICAN ASSOCIATION OF HOSPITAL ACCOUNTANTS, Indiana University, Bloomington, Ind., July 13-18.

INTERNATIONAL CONGRESS ON MEDICAL RECORDS, London, England, Sept. 7-12.

INTERNATIONAL CONGRESS OF PHYSICAL MEDICINE, London, July 14-19.

IOWA HOSPITAL ASSOCIATION, Kirkwood Hotel, Des Moines, April 23.

KANSAS HOSPITAL ASSOCIATION, Town House, Kansas City, Nov. 6, 7.

MAINE HOSPITAL ASSOCIATION, Belgrade Hotel, Belgrade Lakes, June 27, 28.

MANITOBA HOSPITAL ASSOCIATION, Royal Alexandra Hotel, Winnipeg, Oct. 22-24.

MARYLAND—DISTRICT OF COLUMBIA—DELAWARE HOSPITAL ASSOCIATION, Hotel du Pont, Wilmington, Del., Nov. 10, 11.

MICHIGAN HOSPITAL ASSOCIATION, Statler Hotel, Detroit, Nov. 16-18.

MISSOURI HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Nov. 20, 21.

MISSISSIPPI HOSPITAL ASSOCIATION, Heidelberg Hotel, Jackson, Oct. 16, 17.

NATIONAL ASSOCIATION OF CLINIC MANAGERS, Palmer House, Chicago, Sept. 28-Oct. 1.

NATIONAL LEAGUE OF NURSING EDUCATION, Atlantic City, N. J., June 16-20.

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, Atlantic City, N. J., June 16-20.

NEBRASKA HOSPITAL ASSOCIATION, Pathfinder Hotel, Fremont, Nov. 13, 14.

NEW YORK STATE ASSOCIATION OF MEDICAL RECORDS LIBRARIANS, Hotel Syracuse, Syracuse, June 11-13.

OKLAHOMA STATE HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 6, 7.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 27-29.

RHODE ISLAND HOSPITAL ASSOCIATION, Miriam Hospital, Providence, Dec. 13.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Alex Johnson Hotel, Rapid City, Oct. 6, 7.

VERMONT HOSPITAL ASSOCIATION, Pavilion Hotel, Montpelier, Oct. 29, 30.

WYOMING HOSPITAL ASSOCIATION, Memorial Hospital, Rock Springs, Sept. 26, 27.

1953

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Palmer House, Chicago, Feb. 10-13.

MASSACHUSETTS HOSPITAL ASSOCIATION, Sheraton Plaza Hotel, Boston, Jan. 20.

OHIO HOSPITAL ASSOCIATION, Netherland Plaza Hotel, Cincinnati, April 6-9.

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In this regard, we request your assistance in weighing the merits of a new system of food service called Mealpack. The meal you have just been served was handled with this equipment.

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1. Meat and vegetables were – (✓) Hotter ( ) Colder ( ) No different
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3. Texture of meat and vegetables was – ( ) Too Moist ( ) Too Dry (✓) Just Right
4. General appearance of hot foods was – (✓) Attractive ( ) Not Attractive ( ) No different
5. Quality of cold food was – (✓) Attractive ( ) Not Attractive ( ) No different
6. Quality of liquid food was – (✓) Attractive ( ) Not Attractive ( ) No different
7. General appearance of tray set-up was – (✓) Appetizing ( ) Not Appetizing ( ) Not noticeably different
8. My General Opinion is – ( ) Prefer old method (✓) Prefer new method
9. I prefer (✓) New Pyrex Dish: or ( ) Regular Dinner Plate
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NEWS...

Harlem Hospital Dedicates Library Honoring Dr. Wright

By HENRY W. KOLBE

NEW YORK.—Dr. Louis T. Wright, director of surgery at Harlem Hospital, New York City, was honored April 30 at a testimonial dinner. Approximately 1000 persons attended.

The dinner was given for the dual purpose of raising funds for the Harlem Hospital library, and for its dedication as the Louis T. Wright Library, in recognition of the outstanding services Dr. Wright has rendered to Harlem Hospital since he first joined the medical staff in 1919.

The co-chairmen were Dr. Ralph J. Bunche of the United Nations and Dr. Henry W. Cave, president of the American College of Surgeons. Walter White, executive secretary of the National Association for the Advancement of Colored People, served as toastmaster.

Mrs. Eleanor Roosevelt, the main speaker, emphasized the importance of such a gathering from the point of view of international relations, and particularly toward improving the standing of our country in its relation with underdeveloped countries throughout the world. Arthur B. Spingarn, president of the N.A.A.C.P., discussed the important rôle that Dr. Wright has played in the accomplishments of the association as chairman of the board of directors; Dr. Marcus D. Kogel, commissioner of hospitals, cited his achievements in shaping the medical policies of the municipal hospitals in New York City, and Vincent R. Impelliteri, mayor of the city of New York, testified to the significant position that Dr. Wright occupies in the medical field, relative to the care and treatment of the medically indigent of the city.

Dr. Wright's career has been a remarkable and outstanding one in the field of clinical and research medicine and surgery. He was the first Negro physician appointed to the staff of a municipal hospital in New York City. This was in 1919. As a result of his efforts, the doors of all municipal hospitals as well as those of voluntary hospitals have been opened to competent and qualified Negro physicians.

Dr. Wright's work in the clinical use of antibiotics has received international recognition. Aureomycin was first used under his direction clinically in Harlem Hospital. He is a recognized authority on the use of antibiotics in lymphogranuloma venereum, granuloma inguinale and the more common venereal diseases. He is director of the Harlem Hospital Cancer Foundation and has contributed articles relative to research in the field of cancer, particularly triethylene melamine.

Dr. Wright, a graduate of the Harvard medical school, class of 1915, cum laude, served in the U.S. Army during World War I and was discharged with the rank of captain. Subsequently, he served in the medical reserve corps of the army, achieving the rank of lieutenant-colonel at the time of the termination of his service in 1942.

Dr. Wright is a fellow of the American Medical Association, the New York State Medical Society, the New York County Medical Society, and of the American College of Surgeons. He was elected to the last position in 1934—the first man of his race to be so honored. He also is a diplomate of the American Board of Surgeons.

Overlook Hospital Selected by Rutgers U. to Assist in Nurse Training Experiment

SUMMIT, N.J. — Overlook Hospital here has been chosen by Rutgers University to provide clinical facilities for practical training of nursing students enrolled in the university's two-year experimental nursing program, it was announced.

Designed for secondary school graduates, the two-year program will help alleviate the current nursing shortage by providing trained nurses after only 22 months of study.

Under the new plan, students will devote two days each week to clinical practice in the hospital. The remainder of the time they will spend at the college, working on professional theory and academic study. Nurse students will be required to take half of the required credits in college level academic subject matter. Because the two-year program is experimental, an additional eight-month internship will be required of all students to verify the success of the curriculum. During this internship, however, students will pay no fees, and will receive $150 per month from the hospital. While at Overlook students may live either at home or at the hospital.

The university has made affiliation with various institutions for the utilization of their facilities in connection with the program. Students primarily

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NEWS...

will make use of Overlook for clinical facilities and for general nursing practice in obstetrics, pediatrics and communicable diseases, during the 22 months of training and during the internship. However, arrangements also have been made for clinical affiliation with the Essex County Isolation Hospital in Belleville, and the Visiting Nurses Association of the Oranges and Maplewood where they will gain experience in psychiatry and public health work, respectively.

Mississippi Service Plans Elect New Directors

JACKSON, MISS. — At the fourth annual membership meeting of the Mississippi Hospital and Medical Service held here recently, the following directors were elected for three-year terms:

W. W. Hollowell, Greenville; Owen Cooper, Yazoo City; the Rt. Rev. Msgr. Joseph Brunini, Jackson; Virgil Youngblood, Brookhaven; Dr. Felix J. Underwood, Jackson; R. M. Castle, Meridian; John W. Gill, Vicksburg; Dr. Lamar Arrington, Meridian; Dr. B. B. O'Mara, Biloxi, and Dr. W. H. Brandon, Clarksdale.

Starts Employe Paper

GRAND RAPIDS, MICH. — Butterworth Hospital here has begun a new publication for its employes entitled *Butterworth Hospital News*. The first issue appeared in February and it will be published every other month.

In introducing the newspaper, Dr. L. V. Ragsdale, superintendent of the hospital, said:

"The need for a publication such as the *Butterworth Hospital News* . . . has long been felt. I am very pleased that we now have the staff and equipment to permit us to use this means of communicating with the Butterworth Hospital family and friends."

ABOUT PEOPLE

(*Continued From Page* 87)

Bradford, Pa., to replace **Raymond F. Hosford,** whose appointment as director of Lankenau Hospital, Philadelphia, was announced in the March issue of The MODERN HOSPITAL. Until recently Mr. Hew had been assistant administrator.

Patrick B. Monaghan has resigned as superintendent of the Tolfree Memorial Hospital, West Branch, Mich., to accept the position of director of the new Ionia County Memorial Hospital, Ionia, Mich. Mr. Monaghan is a member of both the Michigan and American hospital associations. He studied hospital administration at the University of Minnesota and the University of Chicago on scholarships awarded by the Kellogg Foundation.

R. Ashton Smith has resigned as assistant director of Muhlenberg Hospital, Plainfield, N.J., to accept the appointment of director of Lawrence General Hospital, Lawrence, Mass. Mr. Smith is a graduate of the Columbia University program in hospital administration and served his administrative residency at the University Hospitals of Cleveland. Mr. Smith will assume his new duties June 1.

Constance Magnuson, R.N., retired June 1 as administrator of the Swedish Hospital, Brooklyn, N.Y., **Dorothy E. Smith,** former office manager, has been named to serve as interim administrator.

Horace E. Hamilton, former hospital

administrator of the North Carolina Medical Care Commission, Raleigh, has been selected to succeed **John W. Rankin** as director of the James Walker Memorial Hospital, Wilmington, N.C.

Roger B. Samuelson has assumed his new duties as administrator of the Susan B. Allen Memorial Hospital, El Dorado, Kan. Mr. Samuelson formerly was a district administrator for the Lutheran Hospitals and Homes Society of Fargo, N.D., assigned to hospitals in Oberlin, Oakley and Hugoton, Kan.

Charles M. Goff, who has been serving as administrative resident during the last year at Miami Valley Hospital, Dayton, Ohio, has been named administrative assistant of the hospital. Mr. Goff, who will be graduated in June from the hospital administration course at Washington University, St. Louis, is a personal member of the American Hospital Association and the Ohio Hospital Association.

Robert P. Chapman assumed his new duties May 5 as administrator of the Davenport Osteopathic Hospital, Davenport, Iowa. He formerly was administrator of the Allentown Osteopathic Hospital, Allentown, Pa. Mr. Chapman also is president of the American Osteopathic Hospital Association, with offices in Columbus, Ohio.


R. J. Reynolds

Raymond J. Reynolds has been appointed administrative assistant at Norwalk Hospital, Norwalk, Conn. Mr. Reynolds, a graduate of the course in hospital administration from Yale University, for the last year has been an administrative resident at Massachusetts General Hospital, Boston. Prior to that he served for a year as administrative assistant at the West Virginia Medical Center, Charleston. He is a former research assistant at Washington University's medical school. He is a member of the American Hospital Association, the Massachusetts Hospital Association, the New England Hospital Assembly, and the American Public Health Association.

Department Heads

Mildred I. Quackenbush, R.N., has been appointed assistant professor of nursing in the school of nursing and supervisor of operating rooms at the University Hospital of the Universtiy of Michigan, Ann Arbor, effective September 1. Miss Quackenbush, who has been supervisor of operating rooms at Rochester General Hospital, Rochester, N.Y., since February 1948, served at Presbyterian Medical Center, New York City, from 1938 to 1942 as staff nurse and head nurse and on private duty. She also served in the U.S. Army Nurse Corps for four years as general staff nurse, instrument nurse, and supervisor of operating rooms.

Robert A. Hedges has been appointed to the newly created position of credit manager of Grace Hospital, Hutchinson, Kan. Until his recent appointment Mr. Hedges was assistant manager of the Hatcher Hospital Clinic of Wellington, Kan. Previous to going to Kansas Mr. Hedges was associated with the Mercy Hospital of Oklahoma City, Okla., and the Municipal Hospital of Norman, Okla. Mr. Hedges is a member of the American Association of Hospital Accountants.

Dr. Charles T. Ashworth will become co-director with **Dr. Dennis Fitzwilliam** of the department of clinical and surgical pathology at Harris Hospital, Fort Worth, Tex., July 1. Dr. Ashworth, who has been associated with Terrell Laboratories since 1948, is an associate professor

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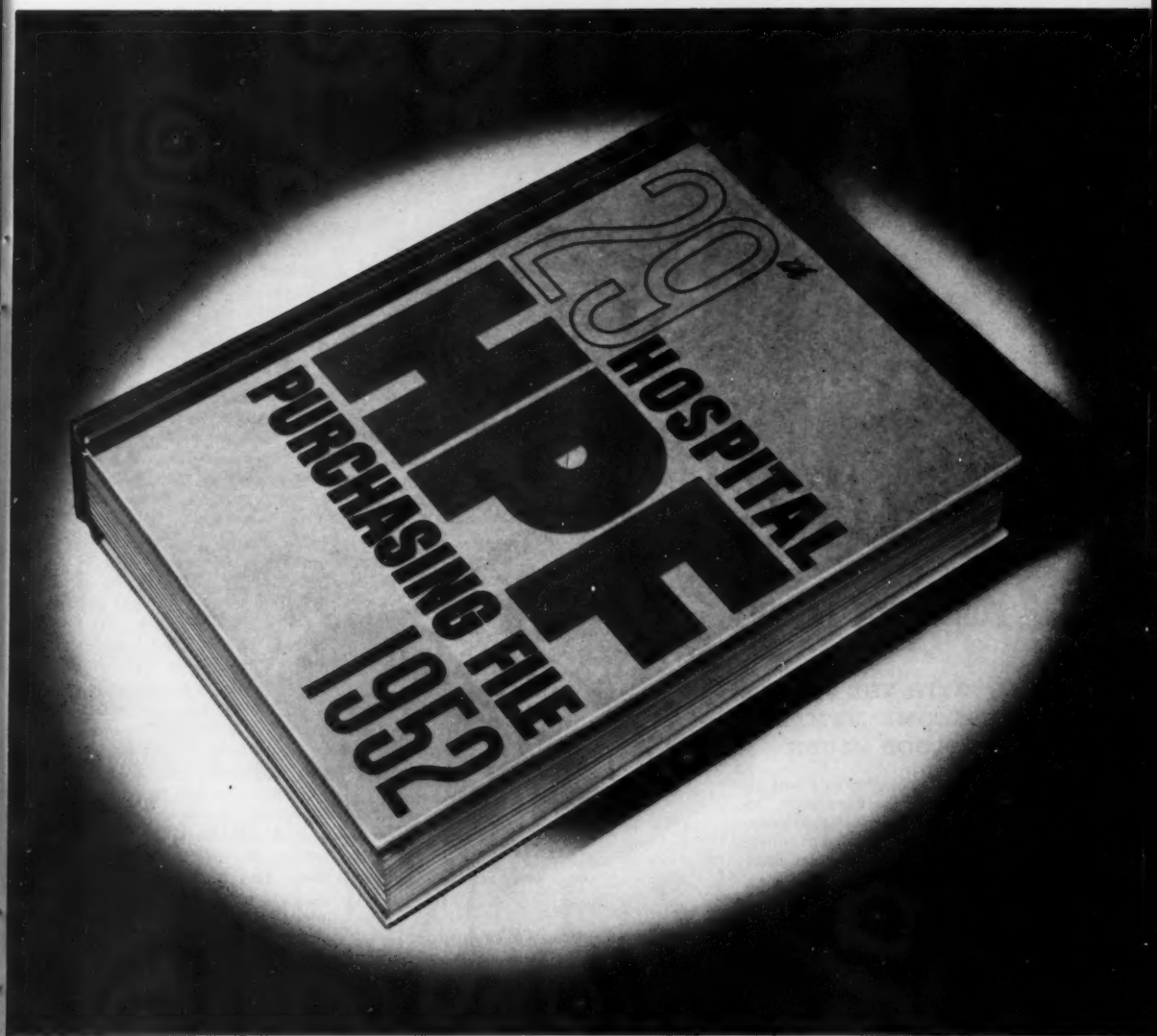

ESTABLISHED AS THE HOSPITAL YEAR BOOK IN 1919 BY THE MODERN HOSPITAL PUBLISHING CO. INC.

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of pathology at Southwestern Medical College in Dallas.

Agnes A. Tremblay, R.N., has assumed her new duties as superintendent of nurses at Augusta State Hospital, Augusta, Me. Another new appointment at the hospital is that of **Phyliss E. Ferguson, R.N.,** as the new director of nursing education.

Miscellaneous

Arthur J. Benline, Manhattan superintendent of the department of housing and buildings since 1939, has been named technical director of the New York State Building Code Commission, succeeding **Albert P. Backhaus,** who has been on leave from his post as principal building engineer for the state of Maryland. Mr. Benline is a member of the American Society of Civil Engineers and the New York State Society of Architects. He is president of the New York State Building Officials Conference and vice president of the Building Officials Conference of America, Inc.

William S. Callahan has been appointed director of personnel in the New York State Department of Mental Hygiene. The appointment became effective May 16. Mr. Callahan has been with the department as assistant director of personnel since November 1945. He formerly was personnel director of the Kenyon Instrument Co., Huntington, N.Y. **Granvill Hills** will succeed Mr. Callahan July 1 as assistant director of personnel. Mr. Hills, who has been with the state department of civil service since 1939, is at present in the classification and compensation division of that department as associate personnel technician.

C. M. Royle

Charles M. Royle has been named the first full-time executive director of the Hospital Association of New York State. Mr. Royle will resign as executive director of the Rochester Regional Hospital Council, Rochester, N.Y. With a five-year grant from the Commonwealth Fund, he has experimented with regional hospital and medical care in an area of 11 New York State counties. For two years he was consultant to the Puerto Rican government in establishing a Bureau of Hospital Survey and Construction. **Carl P. Wright,** superintendent of the General Hospital of Syracuse, N.Y. recently resigned as the hospital association's part-time executive secretary.

Dr. Dean W. Roberts is the newly appointed director of the Commission on Chronic Illness, succeeding **Dr. Morton L. Levin,** who has been on leave of absence since 1950 from the New York State Department of Health. Headquarters of the national commission will be transferred from Chicago to Baltimore on July 1 when Dr. Roberts will assume his new duties. Until his recent appointment he was deputy director of the Maryland State Department of Health.

Dr. Otis L. Anderson is the newly appointed chief of the Bureau of State Services, Public Health Service, succeeding the late **Dr. Joseph W. Mountin.** A former associate chief of the Bureau of Medical Services, Dr. Anderson will direct the broad federal-state and interstate programs of the service. Dr. Anderson is a fellow of the American Medical Association and of the American College of Physicians; a diplomate of the American Board of Preventive Medicine and Public Health, and a member of the American Public Health Association, the American Hospital Association, and the Association of Military Surgeons.

Leon A. Korin has joined the staff of the Hospital Council of Philadelphia as

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research associate. Previously, he was with the medical administrative corps of the U.S. Air Force, and he also did personnel work for the Hebrew Immigrant Aid Society.

Trustees

Raphael B. Malsin has succeeded **Ralph F. Colin** as president of the Hospital for Joint Diseases, New York City. Mr. Malsin, president of Lane Bryant, Inc., has been a trustee of the hospital since 1947. **Leopold Friedman** and **Oscar S. Rosener** were reelected vice presidents; **Martin L. Katzenstein** was elected a vice president; **Willard E. Loeb** was reelected treasurer, and **Gustave L. Levy** was reelected secretary.

Deaths

Dr. J. W. Mountin

Dr. Joseph W. Mountin, chief of the bureau of state services of the Public Health Service, Federal Security Agency, died unexpectedly April 26 at the Naval Medical Center, Bethesda, Md. A Public Health Service officer for the last 35 years, Dr. Mountin was appointed to the post of bureau chief in 1951, with the rank of assistant surgeon general. He was a special health adviser to the Bhore Commission for the government of India in 1947. During 1949, he was adviser on health and welfare to the economic mission to Colombia, South America, sponsored by the International Bank for Reconstruction and Development. At the time of his death, he was Public Health Service director of the evaluation of the 10 year health and sanitation program of the Institute of Inter-American Affairs. The author of numerous studies and monographs on preventive medicine, public health administration and medical care, Dr. Mountin was a diplomate of the American Board of Preventive Medicine and Public Health and a fellow of the American Medical Association. He also was a member of the executive board of the American Public Health Association and the board of the National Organization for Public Health Nursing.

Dr. Joseph Morton Sheridan, former medical superintendent of Fordham Hospital and later Gouverneur Hospital, both in New York City, died May 5 in Baton Rouge, La. Dr. Sheridan, who had been associated with the New York Department of Hospitals for 25 years, resigned in 1950 because of failing health.

THE BOOK SHELF

JOB DESCRIPTIONS AND ORGANIZATIONAL ANALYSIS FOR HOSPITALS AND RELATED HEALTH SERVICES. *Compiled by the United States Employment Service in Cooperation With the American Hospital Association. Washington, D.C.: Government Printing Office.* 1952.

This is a most comprehensive and useful volume of job descriptions applying specifically to hospital and health service positions. It contains detailed descriptions of a majority of the jobs common to hospitals. The descriptions are helpfully arranged by major departments, and each department is described in terms of function and responsibility, staffing, relationship to other departments, and physical facilities required.

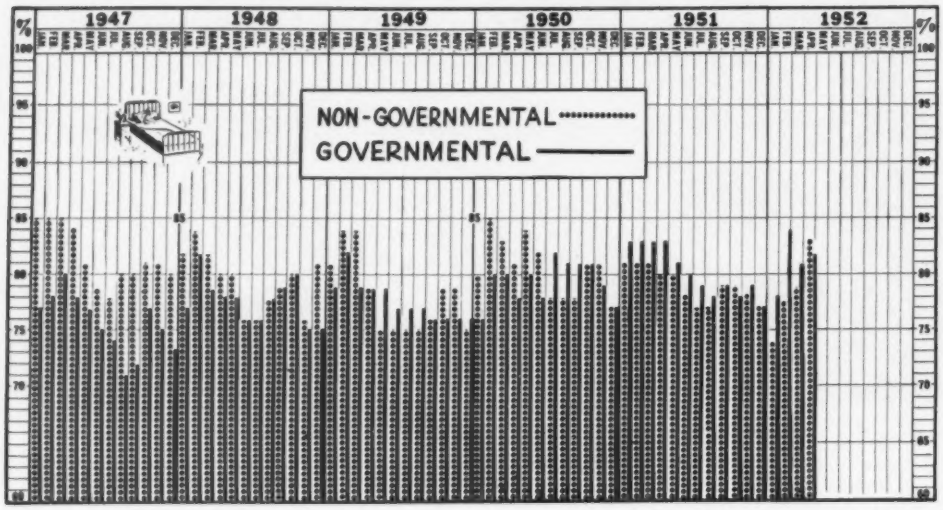
The individual descriptions are necessarily composites of many similar jobs in a number of hospitals. This means that they are broad and detailed. Smaller hospitals often combine two or more of these jobs, while larger institutions may subdivide them even further. Alternate job titles have been included to help identify the positions.

The practical uses of this volume are many. First, it furnishes the best overall coverage of hospital positions which has ever been attempted in job description form. Every hospital can utilize this volume as a guide in studying its own organization plan, in compiling its own written job descriptions, and in working toward a common hospital nomenclature for job titles.

Second, this volume furnishes accurate vocational information to public and private employment services, vocational counselors, and persons attracted to hospital employment. The introduction to the volume shows great insight into the complexities of hospital operations in a section entitled "The Hospital."

A previous publication of the A.H.A. set up brief job descriptions in 1940. They have been of great value during the last decade in stimulating additional work in this field by individual hospitals, since they represented a pioneer effort in the direction of compiling specialized job descriptions applicable particularly to hospitals. The current work is in every sense a professional, workmanlike job of bringing together in usable form a large amount of job information.—MORTIMER ZIMMERMAN.

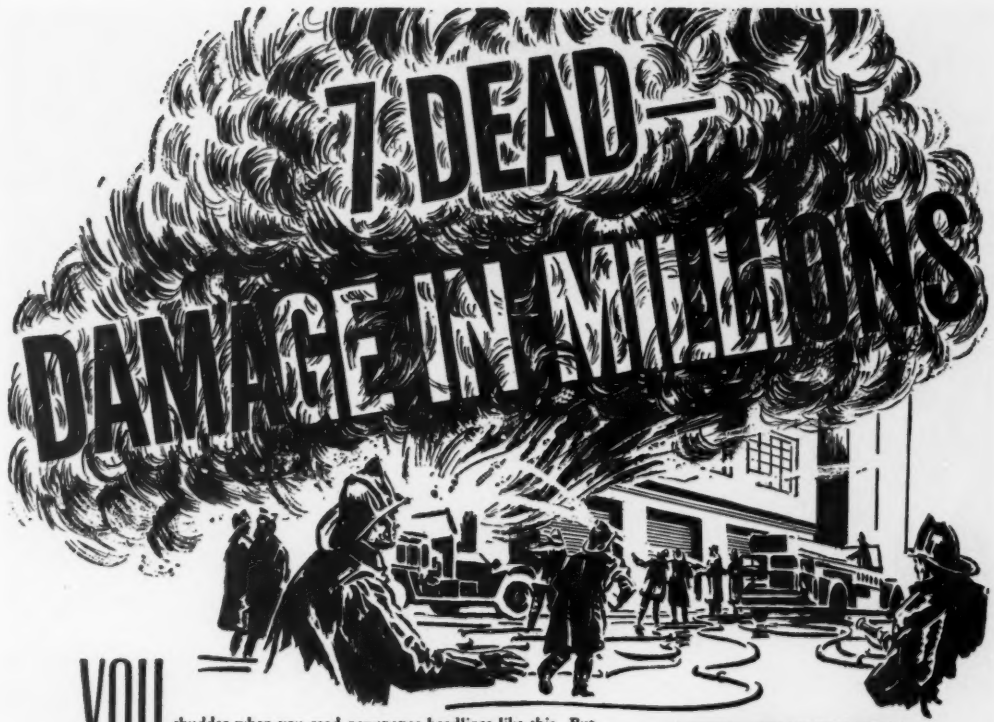
Voluntary Hospital Occupancy Above 1951 Figure



Reports from nongovernmental hospitals to the Occupancy Chart for the month of April indicate an average daily occupancy of 83 per cent of capacity, compared to 80 per cent for the same hospitals during April 1951.

Government hospitals have reported 81.2 per cent occupancy — 2 points lower than last April's figure.

New hospital construction reported for the period ending May 5 amounted to $60,869,797. Construction for 1952 thus far totals $192,680,014. The amount for the corresponding period a year ago totaled $319,292,796. Projects reported during the two-week period include 24 hospitals, 29 additions, and three alterations to existing units.



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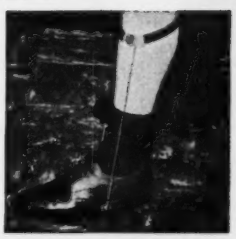

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nu-grain refinishers can give your old furniture a "new look." **nu-grain*** refinishes and modernizes your old fashioned furniture. See for yourself how economically **nu-grain** can modernize and refinish your hospital furniture.

The wood grain is treated with nu-grain materials to give a durable, scratch, stain, and alcohol resistant finish.

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*__nu-grain__ *is not a paint,* __nu-grain__ *is an at-the-factory process. All work is done at the* __nu-grain__ *plant.*

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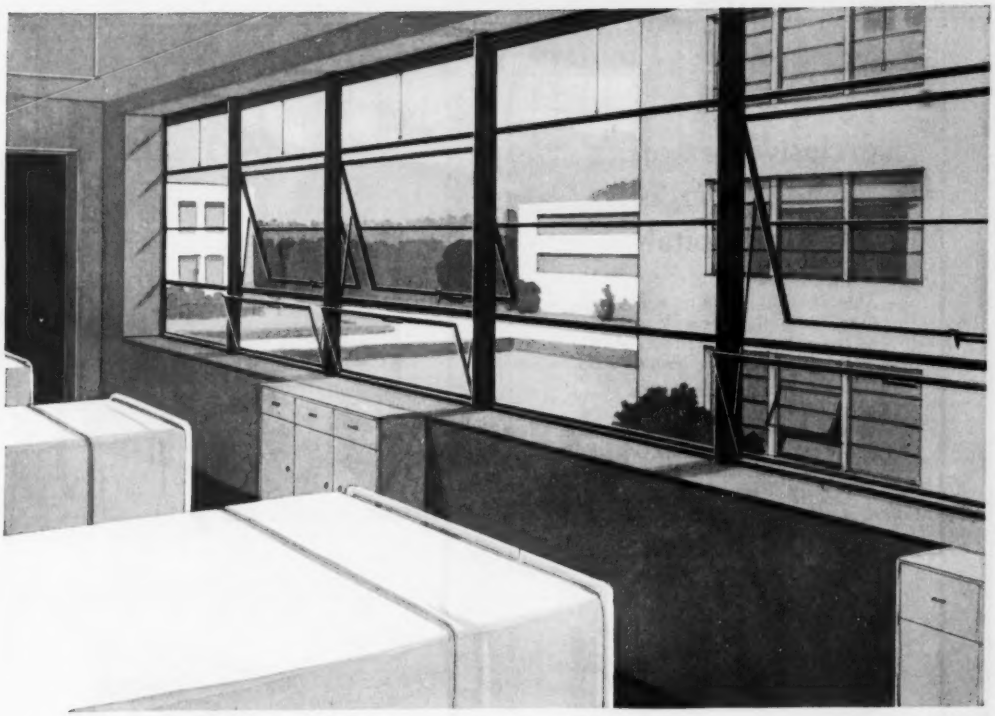

Here's a Ward that deserves an award — its Lupton "Master" Aluminum Windows give it decided advantages.

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POSITIONS WANTED

ADMINISTRATOR—FACHA; broad experience; excellent references; available immediately for emergency or advisory service; temporary or permanent, anywhere. MW 67, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—B.S., Home Economics; 1½ years, hospital tea room; sanitation, Duke University Hospital; 3 years assistant dietitian, general hospitals; references; prefer east. MW75, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

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Cleveland, Ohio

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ADMINISTRATOR—4 years Walton School of Commerce; administrative residency, 2 years, 200-bed Illinois hospital; 7 years administrator, 125-bed midwestern hospital.

ASSISTANT ADMINISTRATOR — Graduate Ohio State University, Degree, Business Administration; 6 years, accountant; 2 years hospital administration course, M.H.A. Degree, 1952.

ASSISTANT ADMINISTRATOR—Experienced laboratory technician; 2 years administrative resident, Sisters' Hospital, midwest; will consider personnel management.

EXECUTIVE HOUSEKEEPER—Experienced college residence director; past four years housekeeper, 200-bed eastern hospital; prefers midwest; south.

The Medical Bureau
M. BURNECE LARSON—DIRECTOR
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ACCOUNTANT—B.S., Accounting and Economics; six years, accountant, 600-bed hospital; will consider business managership plus accounting.

ADMINISTRATOR—A.B., M.S., Hospital Administration; nine years, administrative staff, large teaching hospital, serving as assistant in charge of personnel and later as assistant in charge of private pavilion; four years, director, general hospital, 260 beds; member ACHA.

ADMINISTRATOR—Assistantship preferred; Master's in Hospital Administration; year's administrative internship; past year, assistant superintendent, 200-bed hospital.

MEDICAL BUREAU—*Continued*

ADMINISTRATOR—Medical; five years, director, voluntary general hospital, 500 beds; six years, director, teaching hospital and on faculty university school of hospital administration; FACHA.

ADMINISTRATOR—Nurse. Graduate, university school of nursing; M.S., Hospital Administration; supervising experience before specializing.

ANESTHESIOLOGIST—Past eight years, director, department of anesthesiology, 700-bed general hospital; Part I American Board completed.

PATHOLOGIST—FCAP, Diplomate, Clinical Pathology, Pathologic Anatomy; eight years, director pathology, large, general hospital and associate pathologist, university school of medicine.

PERSONNEL DIRECTOR—Master's, Business Administration; six years, personnel director in industry; five years, personnel director, large teaching hospital.

RADIOLOGIST—Professor of radiology, one of country's leading universities and chief of x-ray, affiliated hospital, since '45; able administrator; Diplomate; FACR.

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ADMINISTRATOR—Member ACHA; several years, administrative assistant, 300-bed hospital; three years, associate director, then Director, 400-bed hospital; very well qualified in all phases.

ADMINISTRATOR—FACHA; five years, assistant administrator, university hospital; past six years, director, 200-bed hospital.

PATHOLOGIST—Diplomate, certified both branches; M.S., Surgical Pathology; completion of five years excellent training; interested hypersensitivity diseases; prefers warmer climate; licensed Louisiana, Texas, New York and New Jersey; immediately available; age 30.

RADIOLOGIST — Diplomate, certified both branches; past six years, director, department of radiology, 700-bed university graduate hospital.

ANESTHESIOLOGIST—Diplomate, American Board; 1 year, anesthesiologist, university hospital; several years, chief, anesthesiology, large hospital; past two years, private practice of anesthesiology; early thirties.

(Continued on page 194)

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PURCHASING AGENT — 16 years' experience 125-425 bed hospitals; immediately available.

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ADMINISTRATOR—Lay, preferably male; community of 30,000 in northeastern Wisconsin already having a 200-bed general hospital; under construction, completion spring of 1953; position open September 1, 1952; would work with architect and consultant during construction, select staff; usual general facilities; state qualifications, experience, and expected salary. Apply to John Stevenson, Manitowoc County Memorial Hospital, 926 South Eighth Street, Manitowoc, Wisconsin.

ADMINISTRATOR—For new hospital, bed capacity 347; active, excluding bassinet; 117 chronic; good opportunity; training and experience essential. Apply, Secretary, Kitchener-Waterloo Hospital Commission, Kitchener-Waterloo Hospital, Kitchener, Ontario, Canada.

ANESTHETIST—For 331-bed general hospital; good working conditions, interested staff; salary $350 per month with maintenance. Write to Frank C. Haythorn, Superintendent, Greenville General Hospital, Greenville, South Carolina.

ANESTHETIST—For 60-bed general hospital in southeastern Wisconsin; short distance from Milwaukee and Chicago; salary open. Inquire, Administrator, Memorial Hospital, Burlington, Wisconsin.

ANESTHETIST—For fully approved 80-bed general hospital in Pacific Northwest; 40-hour week; salary open. MO 81, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; salary dependent upon experience. Write, wire or call collect, Joseph G. Norby, Administrator, Columbia Hospital, 3321 North Maryland Avenue, Milwaukee, Wisconsin.

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POSITIONS OPEN

ANESTHETIST—Nurse, A.A.N.A. member preferred; $350 monthly plus full maintenance; 3-week vacation, sick leave, Blue Cross insurance; 250-bed hospital, fully approved; surgical staff all Board diplomates. Washington Hospital, Washington, Pennsylvania.

ANESTHETISTS—Nurse: for 150-bed community hospital; four nurses, full time M.D., all agents and techniques; good opportunity for advanced training; full maintenance and one month's vacation; two and one-half hours from Boston and New York. Write, G. J. Carroll, M.D., William W. Backus Hospital, Norwich, Connecticut.

ANESTHETISTS—Nurse: two urgently needed; modern, well equipped, 100-bed hospital, employing only graduate staff; attractive location within forty minutes of San Francisco; 5-day week; excellent salary; maintenance available. Administrator, Alameda Hospital, Alameda, California.

ANESTHETISTS—Nurse; for 340-bed AMA and ACS approved hospital; department headed by physician anesthetist; room available in nurses' residence. Mount Sinai Hospital, 2750 West 15th Place, Chicago 8, Illinois.

ANESTHETISTS—Nurse; general 188-bed hospital; no obstetrics, excellent personnel policies; starting salary $350; maintenance optional. Apply, Superintendent, Trinity Hospital, Minot, North Dakota.

DIETITIAN—Approved modern hospital of 200 beds in midwest city has opening for a chief administrative dietitian; this position is attractive because of nice working conditions and real opportunity it affords; 50 persons in dietary department; $400; living quarters available; would like to tell you more about this position. MO 86, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—Therapeutic: 300-bed approved general hospital, in central Pennsylvania. Apply, D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

DIETITIAN—For 100-bed hospital; salary depends on experience and qualifications. For particulars apply, Superintendent, Soldiers' Memorial Hospital, Campbellton, New Brunswick.

DIETITIAN—Assistant; A.D.A. member; for 485-bed hospital located in attractive residential section; excellent salary with opportunity to advance. Address application to: Personnel Director, Touro Infirmary, 3516 Prytania Street, New Orleans, Louisiana.

DIETITIAN—Assistant and therapeutic; immediate opening, 200-bed approved hospital in western suburb of Chicago. Apply, Dietitian, Memorial Hospital, Elmhurst, Illinois.

(Continued on page 196)

DIETITIAN—Therapeutic dietitian for an approved hospital of 200 beds in city of 75,000, midwest; a real opportunity for someone who would like to join a fine staff; salary range from $299 to $325 depending on experience; immediate opening. MO 87, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIANS—Therapeutic and administrative; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $245 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIANS—Female; some experience; salary $3420 to $4140 per annum. For details, write or call The Fairfield State Hospital, Newtown, Connecticut.

DIRECTOR — Educational; for accredited school of nursing connected with 330-bed general hospital; 1 class admitted annually; plans for university association; salary open; 44-hour week, 3 holidays, 4 weeks vacation, 12 days sick leave. Apply, Director of Nursing, Perth Amboy General Hospital, Perth Amboy, New Jersey.

DIRECTOR—Educational; degree required, experience preferred; accredited school of nursing connected with 300-bed, well equipped, general hospital; one class annually; sciences taught at nearby college; salary open, all cash; room available, if desired; liberal personnel policies; hospital located near New York, Philadelphia and the Atlantic coast. Apply, Director of Nursing, Mercer Hospital, Trenton, New Jersey.

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POSITIONS OPEN

DIRECTOR OF NURSES—Assistant; for 442-bed institution located in Delaware; Degree in Nursing Education required; salary depends upon qualifications and experience of the applicant; maintenance and apartment included. Apply to Director, School of Nursing, Delaware Hospital, Wilmington, Delaware.

DIRECTOR OF NURSES—72-bed hospital expanding to 130 beds, located in progressive small community; 44-hour week; vacation, sick leave, social security; attractive apartment; salary open, depending on qualifications. Audrain Hospital, Mexico, Missouri.

DIRECTOR OF NURSING—In 140-bed general hospital with school of nursing of 60 students; construction beginning on 50-bed addition; salary to begin at $400 per month; in middle west, near city of 200,000. MO 74, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSING—Assistant; 350-bed hospital; degree and experience desired; 40-hour week. Apply to: Director of Nursing, University of Pennsylvania Graduate Hospital, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

INSTRUCTOR—Nursing arts; degree in nursing education required; experience desirable; salary open. Apply, Director of Nursing, Franklin Hospital, San Francisco 14, California.

INSTRUCTOR—Clinical; to teach orthopedics and the communicable diseases; salary for degree and experience $3804 to $4164; retirement program and social security; 441-bed hospital in a beautiful 40-acre park; liberal personnel policies. Apply, Director of Nurses, Reading Hospital, Reading, Pennsylvania.

INSTRUCTOR—Clinical, in pediatric nursing; needed by July 1 for a fully accredited school of nursing; B.S. in Nursing Education and teaching experience required; salary open; attractive personnel policies. Write, Director, Division of Nursing, Nazareth College, Nazareth, Michigan.

INSTRUCTOR—Nursing arts; for 192-bed hospital, 70 students; immediate opening; new educational department under construction; salary open. Apply to Director of Nursing, House of the Good Samaritan, Watertown, New York.

INSTRUCTOR—Nursing arts; for basic professional program in school of nursing affiliated with university offering B.S. Degree in Nursing; 300-bed hospital; school enrollment 200 students; degree necessary; starting salary open; position open immediately; good personnel policies. Apply, Director of Education, Arkansas Baptist Hospital, 13th and Wolfe Streets, Little Rock, Arkansas.

INSTRUCTOR—Science; for 100-bed general hospital school of nursing; good working and living conditions; salary open, depending upon training and experience. Apply, Director of Nursing Science, Pulaski Hospital, Pulaski, Virginia.

INSTRUCTOR—Science; August 1-15; diploma school, fully accredited by National Nursing Accrediting Service; within walking distance of Columbia University; excellent opportunity for graduate study by person with several years' teaching experience; salary open. Write, Director of Nursing, St. Luke's Hospital, New York 25, New York.

INSTRUCTOR—Science; microbiology and assistant in chemistry or assistant in anatomy and physiology; six science instructors in department; salary for degree and experience $3804 to $4164; retirement program and social security; 441-bed hospital in beautiful 40-acre park; liberal personnel policies. Apply, Director of Nurses, Reading Hospital, Reading, Pennsylvania.

INSTRUCTORS—Clinical; medical and surgical nursing; degree and teaching experience required; salary open depending upon educational background and experience. Apply, Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

INSTRUCTORS—Nursing arts; degree required; for 97-bed hospital; 53 students; located in Susquehanna River Valley, college town; salary $3600 gross; liberal personnel policies. Apply, Director of Nurses, Lock Haven Hospital, Lock Haven, Pennsylvania.

LIBRARIAN—Medical record; for fully approved 80-bed general hospital in Pacific Northwest; 40-hour week; salary open. MO 82, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

(Continued on page 198)

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POSITIONS OPEN

MATRON—For new, fully modern 36-bed hospital; attractive surroundings and ideal working conditions; separate nurses' residence; cumulative sick leave; 1 month holiday after 1 year service; duties to commence immediately. Apply, stating salary expected, qualifications and experience, Mrs. M. Hamilton, Secretary-Treasurer, District Memorial Hospital, Neepawa, Manitoba, Canada.

MISCELLANEOUS—General duty nurses. Supervisors, combined Laboratory and X-ray technician. Refer correspondence to, Myrtice F. Sheffield, R.N., Superintendent, Suwannee County Hospital, Live Oak, Florida.

MISCELLANEOUS — (a) Director-instructor, school of practical nursing; also four Registered nurses: Ganado Mission, Ganado, Arizona. (b) Director of nurses; also Science teacher; Presbyterian Hospital, San Juan, Puerto Rico. (c) Nursing supervisor qualified to give anesthesia, Valley Hospital, Palmer, Alaska. (d) School nurse, Sheldon Jackson Junior College, Sitka, Alaska. Urgently needed; all candidates must be single, Protestant, in good health, and under fifty. Write, Department of Missionary Personnel, PRESBYTERIAN BOARD OF NATIONAL MISSIONS, 156 Fifth Avenue, New York 10, New York.

MISCELLANEOUS—Educational director, Nursing arts instructor, Clinical instructor, Surgical floor supervisor, Assistant director nursing service, for a splendid small hospital; excellent personnel policies; salary scale equals State Nurses' Association figures; write at once for these vacancies will not last long. MO 80, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE—Head, for new 13-bed psychiatric unit in teaching hospital affiliated with Northwestern University; must have special training in this field; the hospital is near the lake and convenient to all types of cultural and recreational facilities; 40-hour week; 4 weeks vacation; paid sick leave; starting salary $285. Apply, Director of Nurses, Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois.

NURSE—Registered; for general duty; meals while on duty and laundry of uniforms. Apply, Business Manager, Lockney General Hospital, Lockney, Texas.

NURSE—General duty, registered, professional; for small maternity home and hospital; 8-hour duty, 40-hour week, alternating shifts; 8 holidays, 14 days sick leave and 3 weeks vacation annually; living quarters available. Write to Executive, Ingleside, 70 Harvard Place, Buffalo 9, New York.

NURSES—Assistant Supervisor 3-11; Staff nurses; 5-day week; additional for 3-11 and 11-7; regular increases to maximum; 2 weeks sick leave after 1 year. Hand Memorial Hospital, Shenandoah, Iowa.

NURSE—Head, for well equipped orthopedic unit in teaching hospital affiliated with Northwestern University; must have degree or postgraduate course; the hospital is near the lake and convenient to all types of cultural and recreational facilities; 40-hour week; 4 weeks vacation; paid sick leave; starting salary $265. Apply, Director of Nurses, Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois.

NURSE—General duty; small growing hospital; good pay, part maintenance; paid vacations; pleasant working conditions. Apply, Supervisor of Nurses, Hi-Plains Hospital, Hale Center, Texas.

NURSES—General duty; for 360-bed general hospital; starting salary $175 per month with maintenance; $200 per month with partial maintenance; rotating shifts; two weeks' vacation; 30 days' sick leave; 6 holidays yearly with pay; 44-hour week; college courses available through night classes at local university. Apply Director of Nursing, Greenville General Hospital, Greenville, South Carolina.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

(Continued on page 200)

classified advertising

POSITIONS OPEN

NURSES—Two: graduate, registered: for general duty in tuberculosis hospital: salary starts $290 per month; 2 weeks annual paid vacation, 6 paid holidays, sick leave, social security, and insurance plan: maintenance available if desired. Apply, Director of Nurses, American Legion Hospital, Battle Creek, Michigan.

NURSES—Graduate: for 80-bed general hospital, positions open all services: general duty, $215 a month, $10 extra for evenings, nights and relief; scrub nurses $225, $2.50 per call case: 6 month increases, for 18 months, merit thereafter; maintenance available; 24 days paid vacation the first year, 32 days thereafter: one day per month sick leave, cumulative to 45 days; 44-hour week. Apply, Director of Nursing, Mahaska Hospital, Oskaloosa, Iowa.

NURSES—Graduate: for new 45-bed, 10-bassinet hospital located at Ripley, Tennessee, population 4500; fifty miles north of Memphis; salary $200 per month, plus meals and uniform laundry; salary increase after ninety days satisfactory service. W. D. Barfield, Administrator, Lauderdale County Hospital, Ripley, Tennessee.

NURSES—Positions available for Operating room charge nurse, also General duty nurses for small, well-equipped hospital on west coast of Florida; 8-hour duty, 6-day week; good salary, vacation with pay, laundry and meals provided; alternate call and bonus for operating nurse. Inquire, Mrs. Dorothy Lednicky, Superintendent, Charlotte Hospital, Punta Gorda, Florida.

NURSES—Operating room and obstetrical: California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $250 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Operating room: fully approved 80-bed general hospital, Pacific Northwest; experience or postgraduate work required; 40-hour week; salary open, depending on experience. MO 85, The Modern Hospital 919 N. Michigan Avenue, Chicago 11.

NURSES—Psychiatric: men and women: for general duty positions open in a psychiatric wing of a 750-bed hospital. Write, Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo, New York.

NURSES—Registered: Hermann Hospital in the Texas Medical Center offers you unlimited opportunities; positions with pleasant working conditions are available now. Write, Director of Nurses, Hermann Hospital, Houston, Texas.

NURSES—Registered, professional: for operating room and general staff duty for all shifts: 44 hours general staff day duty, 40 hours operating room and evening and night duty; beginning salary $200 per month for staff duty, $260 per month for instrument nurses with advanced preparation and experience: liberal personnel policies; social security. Apply, Director of Nurses, Christ Hospital, Jersey City, New Jersey.

NURSES—General staff: 250-bed general hospital and 72-bed maternity hospital; starting salary $240; $5 per month tenure increase for each six months of service to a maximum of $270; two meals daily; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night duty; $15 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 5 years; 6 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Staff and operating room: 5 days, 40 hours, 8 holidays and vacation with pay; initial salary, $230 plus laundry; increases at 6, 12 and 24 months; additional pay for evening and night assignments and for operating room calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

NURSES—Staff: for a general hospital on medical, surgical and obstetric services; also vacancies on operating room staff; good personnel policies. Apply to Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo, New York.

(Continued on page 202)

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NURSES—Staff: for 50-bed hospital. Apply, Administrator, Delaware Valley Hospital, Walton, New York.

NURSES—Staff: for 8-hour, 5-day week, rotating service; salary $255 with full maintenance or $285 one meal and laundry; holidays, sick leave and paid vacation. Apply, Frances Halverstadt, R.N., Superintendent of Nurses, Municipal Contagious Disease Hospital, 3026 South California Avenue, Chicago, Illinois.

NURSES—Staff: three; for modern 70-bed hospital with 10-bed addition to be open June 1; 41-hour week; good salary with or without maintenance; and best of working conditions. Call or wire collect if interested: Winter Haven Hospital, Winter Haven, Florida.

NURSES—Staff: hospital for children with rheumatic fever; excellent salary, good working conditions, maintenance, vacation; near New York City. Apply, Executive Director, Irvington House, Irvington, New York.

NURSES—Staff: for general hospital; 40-hour, 5-day week; $250 with laundry of uniforms; $10 additional for evening, night, maternity duty; increases yearly; must be eligible for registration in California; housing available. Write, Mercy Hospital, Sacramento, California.

NURSES—Suture, for operating room; for 369-bed teaching hospital located in a community 17 miles from New York City; 40-hour week; minimum salary $225 per month. Apply, Director of Nursing, New Rochelle Hospital, New Rochelle, New York.

PHYSICIAN—Resident: for active thoracic surgery service; salary commensurate with experience; includes maintenance; tuberculosis hospital. Write directly to Dr. Nathan Levene, Hazelwood Sanatorium, Bluegrass Avenue, Louisville, Kentucky.

SUPERVISOR—Operating room; for Roper Hospital, Charleston, South Carolina. For further information apply to Ruth Chamberlin, Director of Nursing.

SUPERVISOR—Pediatric; for 442-bed institution located in Delaware; student body of 165; applicant must have a degree in nursing education, or be working for a degree; salary depends upon qualifications of the applicant. Apply to Director, School of Nursing, Delaware Hospital, Wilmington, Delaware.

SUPERVISOR—Pediatric; for accredited 330-bed general hospital, small school of nursing; new 32-bed pediatric unit opened February 1; salary open; 44-hour week, 8 holidays, 4 weeks vacation, 12 days sick leave. Apply, Director of Nursing, Perth Amboy General Hospital, Perth Amboy, New Jersey.

SUPERVISOR—Operating room: for 100-bed general hospital, located in southwest Virginia; excellent working and living conditions; salary open. Apply, Superintendent of Nurses, Pulaski Hospital, Pulaski, Virginia.

SUPERVISOR Operating room: for 345-bed hospital with expansion program; 44-hour week, no Sunday work; living accommodations, if desired; liberal personnel policies affecting vacation and sick leave; experience and advanced preparation required; person with degree will be given preference; salary open. MO 63, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—Operating room: large hospital, active service; position open October 1; mature experienced person; salary open, annual increments; vacation and sick time; 48-hour week, straight shift; travel expenses for personal interview. Apply, Superintendent of Nurses, Winnipeg General Hospital, Winnipeg, Manitoba, Canada.

SUPERVISOR — For department of forty beds, medical and surgical patients; 150-bed general hospital with school of nursing; nurses' aides; salary depends on ability and experience; southeastern Ohio. Apply, Ruth Brant, Administrator, Martins Ferry Hospital, Martins Ferry, Ohio.

(Continued on page 204)

Dr. Howell's Clinic at Canton, Miss. Is cooled with a Frick Unit Air Conditioner. Installation by The Munford Engr. Co., Jackson.

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You get this extra quality when you buy Frick Units. They're better designed, more carefully built, and are installed by experienced refrigerating engineers. They are honestly rated: by actual comparison, Frick Units deliver more cooling effect per dollar invested.

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Here's another outstanding modern kitchen equipped by PIX. Through practical use—the kitchens at the Psychosomatic and Psychiatric Institute have proven to be efficient and economical—meet with the enthusiastic approval of the entire dietary staff.

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POSITIONS OPEN

SUPERVISOR—Obstetrical: fully approved 80-bed general hospital, Pacific Northwest; experience or postgraduate work required; 40-hour week; salary open. MO84, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—Clinical teaching, communicable diseases, for nationally accredited school of nursing affiliated with Northwestern University; exceptionally well equipped polio unit; must have degree or postgraduate course; community offers outstanding cultural and recreational advantages; 40-hour week; 4 weeks vacation; paid sick leave; starting salary $270. Apply, Director of Nurses, Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois.

SUPERVISOR—For medical-surgical floor; fully approved 80-bed general hospital in Pacific Northwest; 40-hour week; salary open. MO 83, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISORS—Two: General ward and Private, for 475-bed general hospital with a school of nursing; approximately 15 minutes from downtown Philadelphia; personnel policies above those minimum employment standards approved by the State Nurses' Association; an overall minimum cash salary of $3300 with regular increments; degree and experience required. Apply, Director of Nursing, The Cooper Hospital, Camden 3, New Jersey.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS—(a) Medical; relatively new hospital, fairly large size; considered one of most important in its section of country; $15-$18,000; west. (b) Medical director; 300-bed hospital, general and tuberculosis; $12,000, home; west. (c) Assistant medical director; medical school and teaching hospital. (d) Lay; voluntary general hospital, 325 beds; east. (e) Large general hospital; outside United States; duties include serving as consultant to other hospitals. (f) General hospital, 175 beds, completed last summer; Pacific coast. (g) To succeed administrator resigning after eighteen years' tenure; general, 200 beds; midwest. (h) Community hospital completed last fall; 160 beds; serves as medical center, population 100,000, resort area, Pacific Northwest. (i) Assistant; general hospital, 600 beds; medical school affiliations; east. (j) Assistant; municipally operated hospital, 700 beds; building program; university center; west. MH6-1

ADMINISTRATORS—NURSES. (a) To succeed third superintendent of voluntary general hospital established 1919; 125 beds; residential town, pleasantly located, east. (b) Convalescent hospital; 150 beds; college town, midwest. MH6-2

(Continued on page 206)

MEDICAL BUREAU—*Continued*

ANESTHETISTS—(a) General hospital operated by group of distinguished specialists; $400-$500; Pacific coast. (b) Association with group of anesthesiologists; college town, midwest. (c) Association with oral surgeon; California. (d) New 225-bed general hospital; university city, southwest; $500. MH6-3

COLLEGE STUDENT HEALTH—(a) Director health program, liberal arts college; 9-month year; minimum $4000; midwest. (b) Director, student health; 300-bed general hospital; New England. (c) School nurse; winter resort; southwest. MH6-4

DIETITIANS—(a) Chief, to succeed director of dietetics resigning after tenure of twenty years; university hospital, 800 beds; expansion program; outstanding woman qualified for faculty appointment required; $5000-$7500. (b) Therapeutic and administrative dietitian; 200-bed hospital affiliated with group of distinguished specialists, on faculty medical school; 40-hour week; attractive city, south. (c) Chief; voluntary, general hospital, 500 beds; university medical center, midwest; minimum $5000. (d) Chief and assistant dietitian; large hospital; $4800-$6000 and $3600-$4800 respectively; California. MH6-5

DIRECTORS OF NURSING—(a) Important hospital, fairly large size; medical school affiliations; New England. (b) Voluntary general hospital, 450 beds; collegiate affiliations; duties with school only; large city, university medical

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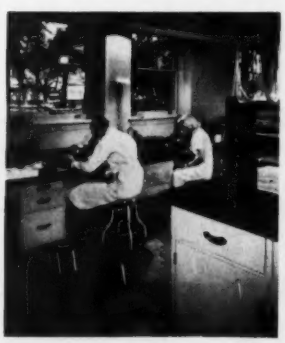

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

center; west. (e) Large teaching hospital; university center, south; $7200. (d) Director, new cancer hospital, unit university group; should know atomic energy nursing, qualified train nurses in technique of radio-active isotopes. (e) New pediatric hospital; privately endowed by foundation; currently under construction; coast city; pleasant year-round climate. (f) Nursing service only; 200-bed general hospital; college town, northwest; $6000, maintenance. (g) Associate director, nursing service; large teaching hospital; university medical center; east. (h) Nursing service; general hospital under construction; completion September; California. MH6-6

EXECUTIVE HOUSEKEEPER—Qualified supervise departments, medical facilities, leading private medical group consisting three hospitals and possibly one of two hotels; staff includes two assistants, sixty-five other employees; major expansion program recently initiated. MH6-7

EXECUTIVE PERSONNEL—(a) Personnel director; important teaching hospital, 600 beds; large city, university medical center. (b) Office manager; accounting background desirable; must be qualified to direct staff of 60, large teaching hospital, university center, east. (c) Chief accountant; large general hospital; Pacific coast. MH6-8

MEDICAL BUREAU—*Continued*

FACULTY APPOINTMENTS—(a) Educational director; 800-bed general hospital, teaching affiliations; 300 students; 100 students admitted annually; university center. (b) Assistant professor; duties consist of conducting in-service program, visiting hospitals throughout state; minimum $5000 plus travel expenses; south. (c) Nursing arts instructor; duties consist of teaching at liberal arts college and school of 300-bed general hospital; college town, midwest; minimum $500. (d) Science instructor; voluntary general hospital, 500 beds, within walking distance to university; opportunity for graduate study; famed school, 250 students; east. (e) Educational director; collegiate school; new program; California; $5000, maintenance. (f) Assistant professor, public health nursing and, also, assistant professor psychiatric nursing; university appointments; former position requires considerable travel, ability develop 4-year collegiate program; salaries: $5000-$6000. MH6-9

MEDICAL RECORD LIBRARIANS — (a) Qualified as statistician to organize and direct departments, 35-man clinic, new hospital 200 beds; university and health resort city, west. (b) To establish and head department, new hospital, general, 500 beds; interesting location; Canada. (c) Chief and assistant; large teaching hospital, university center, midwest. (d) Chief; one of leading hospitals, Chicago area. MH6-10

(Continued on page 208)

MEDICAL BUREAU—*Continued*

SUPERVISORS—(a) Chief operating room; surgical hospital, principally major surgery; medical school affiliations; $5000; east. (b) Medical and surgical floor; one of California's finest hospitals; liberal personnel policies. (c) Outpatient; 15,000 patients annually; teaching hospital, university town; opportunity continuing studies. (d) Obstetrical; new community hospital, 175 beds, serving as medical center to population of 100,000; Pacific Northwest. (e) Pediatric; 40-bed division; 300-bed hospital; university center; east; $300, up. (f) Orthopedic; well staffed department; southern California. MH6-11

INTERSTATE HOSPITAL AND PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ASSISTANT DIRECTORS OF NURSING—(a) Charge of nursing service; 425-bed midwestern hospital; $5000. (b) 300-bed hospital, south; $4500.

NURSE ADMINISTRATORS—$4500-$5000.

DIRECTORS, NURSING EDUCATION — $5000.

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POSITIONS OPEN

INTERSTATE—*Continued*

FOOD SUPERVISORS—(a) Large tuberculosis sanatorium; east; $5000, maintenance. (b) Southern college; $3600, maintenance.

DIETITIANS—(a) Chief; $375-$400. (b) Therapeutic; attractive locations; $350.

TECHNICIANS—(a) X-ray; chief; $4200. (b) Laboratory; $3600. (c) Laboratory and X-ray; to $275, maintenance. East; midwest; west.

EXECUTIVE HOUSEKEEPERS—(a) 320-bed hospital, New York. (b) New hospital, west. (c) 175-bed Ohio hospital. (d) 250-bed hospital, Pennsylvania.

PHARMACISTS—(a) New Sisters' hospital, midwest. (b) 350-bed hospital, east.

CHIEF ACCOUNTANTS—(a) 500-bed hospital, suburb, New York. (b) 350-bed Ohio hospital. (c) 200-bed hospital, central states; university city; $5000.

ADMINISTRATORS—(a) 140-bed specialized hospital; private; midwest. (b) 100-bed hospital; Ohio; 75-bed addition under construction; $7000. (c) New hospitals, southern states; open July. (d) Modern hospital, 65 beds; east. (e) 90-bed hospital, suburb midwestern city.

SHAY MEDICAL AGENCY
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55 East Washington Street
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HOSPITAL ADMINISTRATOR—Middle west; 120-bed hospital with program well under way for a 75-bed addition; located in city of about 25,000; $7000 minimum to start.

PERSONNEL DIRECTOR—Middle west; 260-bed hospital affiliated with well known university; previous hospital personnel experience not required but must have good educational background in personnel; $5000 minimum to start.

BUSINESS MANAGER—East; nationally known clinic and hospital, 75 beds; supervision of bookkeeping machine operators, admitting clerks and all other business office personnel; excellent opportunity.

DIETITIAN—Middle west; 200-bed general hospital in city of 75,000; complete charge of dietary department; experienced, cooperative staff; $4800 to start.

CHIEF MEDICAL RECORD LIBRARIAN—East; 240-bed hospital; department recently reorganized and enlarged; has adequate, well trained staff; system being changed to Standard Nomenclature; $350.

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PAULINE KLASFELD, DIR.

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ADMINISTRATORS—(a) Lay; 350-bed general hospital, New York City area; $12,000. (b) Medical, deputy superintendent, tuberculosis hospital; east.

ADMINISTRATOR—NURSE. Assistant director, nursing education, New York City hospital.

ANESTHETISTS—(a) M.D., 200-bed hospital, mid-Pennsylvania. (b) Nurse, 225-bed hospital, Connecticut; $4500. (c) Nurse, 200-bed hospital, New Jersey; $325 month.

DIETITIANS—Many openings, chiefs and assistants, New York City and surrounding areas.

EXECUTIVE HOUSEKEEPER—30-45; some knowledge chemistry and textiles; 350-bed hospital, New York City.

SUPERVISOR—Obstetrics; 200-bed hospital, mid-Pennsylvania.

(Continued on page 210)

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ADMINISTRATORS—(a) Medical: general hospital of fairly large size; requires good administrative experience; large medical center city; west. (b) Lay; to coordinate services of several hospitals; foreign appointment; 2-year contract; owned by one of America's leading companies; requires MHA. (c) Lay: 500-bed hospital with medical school affiliation; also large clinic; very desirable city 450,000. (d) Lay: assistant; 450-bed hospital affiliated with several colleges and university medical school; excellent policies; very cooperative Board; city 175,000. (e) Lay; chief of administration, department of medical services; 325-bed general and tuberculosis hospital; emphasis on personnel, supply and admittances; island of the Pacific; under auspices United States Government, not Civil Service. (f) Assistant; university medical center comprising large teaching hospital, convalescent and tuberculosis hospitals; 600 beds; opportunity to teach; requires member or nominee, ACHA, with minimum of 4 years experience; outstanding potential. (g) Specialist in hospital administration; to affiliate with one of America's outstanding hospital consulting groups; must be highly qualified, member ACHA, willing to do some traveling and headquarter in New York or Chicago. (h) 300-bed general, voluntary hospital; chiefly devoted to acute illnesses; very large staff of distinguished specialists; eastern seaboard. (i) Lay; 300-bed teaching hospital; university medical center city 500,000.

ADMINISTRATIVE STAFF APPOINTMENTS—(j) Supervision of accounts and purchasing; 150-bed general, voluntary hospital; New England. (k) Combination credit and business manager; develop credit procedure; manage general office and assist administrator; requires hospital administrative residency or equivalent training; fairly large hospital; midwest. (l) Business manager; general, voluntary hospital enlarging to 300 beds; about $6000; large California coastal city. (m) Business manager; 50-bed hospital just opened; Carolinas.

(Continued on page 212)

WOODWARD—*Continued*

ADMINISTRATORS—NURSE. (a) General hospital, 60 beds, planning remodeling program; excellent staff; residential community near university city; $4500 plus maintenance; midwest. (b) Young nurse with administrative background qualified to administer 35-bed convalescent facility; well endowed; about $4000, complete maintenance; university medical center city; New England. (c) 140-bed, important children's orthopedic center; preferably one with previous experience of administration in convalescent home or hospital; delightful city 175,000; to $4800; north-central. (d) fairly new 30-bed general voluntary hospital; excellent facilities including blood bank; lovely residential town near metropolis; northeast. (e) Small hospital soon to be enlarged to 30 beds; excellent staff; residential town near university medical center; southwest. (f) 30-bed general hospital; small town near university medical center; Wisconsin.

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LIBRARIAN—Male, under 40; Degree in Library Science and experience, to supervise well organized medical records department and library, in a 450-bed rapidly expanding general hospital; excellent salary.

NURSE ANESTHETIST—General hospital employing several; liberal personnel policies; start $400 plus full maintenance.

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POSITIONS OPEN

MEDICAL PERSONNEL EXCHANGE—*Continued*

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ASSISTANT DIETITIAN—New York City area; $175 plus full maintenance; ADA not required.

ASSISTANT HOSPITAL ADMINISTRATOR, REGISTERED NURSE—120-bed general hospital; start $4200; maintenance includes 3-room apartment.

PHARMACIST—Assistant; $300 or better; 5½-day week.

EXECUTIVE HOUSEKEEPER—Under 50; 525-bed general hospital.

MEDICAL RECORD LIBRARIAN—Registered or eligible; 120-bed hospital.

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(Continued on page 214)

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(Continued on page 216)

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A professional statement of completion will be granted by Columbia University upon satisfactory completion of the three months course.

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For full information, write to Miss Marguerite Abbott, Executive Director, Coordinating Council for Cerebral Palsy, 270 Park Avenue, New York 17, New York.

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Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

Classes admitted every other month beginning February. Maintenance and stipend of $75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

LOS ANGELES COUNTY GENERAL HOSPITAL SCHOOL OF NURSING offers a twelve weeks course in premature infant nursing to graduate nurses. The University of Southern California will grant up to six units of credit to those nurses who desire it. Course includes formal instruction, clinical experience in unit technic, teaching and public health experience. For further information write to Director, School of Nursing, Los Angeles County General Hospital, 1200 North State Street, Los Angeles 33, California.

COURSE IN ANESTHESIA—ST. FRANCIS HOSPITAL, Peoria, Illinois, offers a comprehensive course in Anesthesia to graduate nurses of accredited schools of Nursing, and is open to Sisters. This course includes all types and methods of Anesthesia in use today. For further information write to Sister M. Borromea, R.N., Director, School of Anesthesiology, St. Francis Hospital, Peoria, Illinois.

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What's New for Hospitals

JUNE 1952 Edited by BESSIE COVERT

TO HELP YOU get information quickly on new products described in this section, we have provided the convenient Readers' Service Form on page 252. Check the numbers of interest to you and mail the coupon to the address given on the form. If you wish other product information, just list the items and we shall make every effort to supply it.

Sterilized Surgical Blades

A. S. R. Sterisharps are announced as an important advance in hospital technic. Sterisharps are sterilized surgical blades, each individually sterilized and packaged, ready for immediate use. They require no preoperative sterilization, thus saving valuable nursing time and eliminating time-consuming technics as well as supplies and equipment normally required to attain safe sterilization without damage to edges.

A feature of the production routine of A. S. R. Sterisharps is a unique Control System for bacteriologic safety. Each sterilized blade is sealed in a sterile container. When opened under sterile technic it is ready for immediate use. **American Safety Razor Corp., Dept. MH, 315 Jay St., Brooklyn 1, N. Y. (Key No. 65)**

Synthetic Detergent

Arctic Syntex HD is a new heavy duty synthetic detergent which is suited to most cleaning problems. It is designed for laundering, wet cleaning and scouring of cotton, synthetic fibers, silk and wool; for cleaning rugs and upholstery; for hand washing of dishes and glassware; for washing laboratory glassware and equipment; for cleaning linoleum, tile, terrazzo, mastic and cement floors; for cleaning painted ceramic, linoleum and plastic tile wall surfaces, and for window, mirror and metal cleaning.

The new product has high detergent efficiency, is easy to use and makes abundant suds. It is unaffected by hard water or metal salts and retains its full detergent effect even in hardest water. It is a good wetting-out and penetrating agent and is effective in alkaline, acid or neutral solutions. Arctic Syntex HD is packed 100 pounds in a fiber drum and is stable under ordinary storage conditions. **Colgate-Palmolive-Peet Co., Dept. MH, 105 Hudson St., Jersey City 2, N.J. (Key No. 66)**

Automatic Ice Flake Maker

The new bantam-sized York-FlakIce Ice Maker DER-2 is sized for diet kitchens and utility rooms. It is designed to produce up to 300 pounds of ice in small clear fragments per day, without the use of an auxiliary crusher. The resulting ice fragments are slightly curved in form, providing a greater exposed surface area and thus faster cooling. They

are ideal in size for ice packs and other therapeutic uses as well as for iced drinks. The small size of the unit permits installation on floors, thus eliminating hauling and handling of ice and making a steady supply available as needed and where needed. The unit is automatic in operation and ice fragments are released through a sanitary ice chute.

The DER-2 has all the features of economy and efficiency that characterize the line of York Ice Makers. The refrigeration circuit is hermetically sealed and the baked enamel outside jacket is finished in hammertone gray. The unit is only 24 inches in diameter and 32 inches high. It is engineered for continuous operation. **York Corporation, Dept. MH, York, Pa. (Key No. 67)**

(Continued on page 222)

Permon Wainscot

Introduced after three years of research and field tests, Permon is a plastifused fabric wall covering intended primarily for wainscot use. It is manufactured by a special process whereby elastomeric resin compounds are fused permanently to a sailcloth backing. It is durable enough to withstand the constant scuffing, wear and impact of rolling equipment required of wainscot. It is attractive and decorative in appearance, is shrinkproof and easy to install, and is washable, stain resistant, stable in color and easy to repair if damaged. Permon can be applied over plaster, wall board, plywood or other surfaces.

Permon is manufactured for horizontal application when used as a wainscot and is supplied pre-trimmed. It is 48 inches wide and a standard bolt contains 30 yards. It is available in 13 standard colors, coordinated with the Fabron wall covering collection to permit the use of a variety of decorative combinations in harmony. Permon Adhesive for applying the product has been specially formulated and is waterproof, after drying, and mildew-proof. It is supplied ready to use. **Frederic Blank & Co., Inc., Dept. MH, 230 Park Ave., New York 17. (Key No. 68)**

Nurses' "Capping" Lamp

To hold the traditional candle at the nurses' capping ceremony and to provide a souvenir of the occasion, the new "Capping" Lamp is appropriate and attractive. Shaped like a miniature Aladdin's Lamp, it is finished in triple silver plate and lacquered, with antimony lead base. A small candle fits in the pointed

tip of the holder which is 4¾ inches long and weighs 10 ounces. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 69)**

What's New . . .

Heated Food Conveyor

Selective menus, ward service and special diets can all be handled in the new All-Purpose Electrically-Heated Food Conveyor introduced by S. Blickman, Inc. Each unit is provided with eighteen square and rectangular top-deck insets in different sizes. These can be arranged to accommodate the variety of foods required for specific menus. Soups and other liquid foods can be carried in the two round wells provided. Two heated drawers and an ample storage compartment are available below.

Bulk hot foods are loaded in the main kitchen and conveyed to serving pantries. Set-up trays are placed on the long side shelf of the conveyor and food is dished up and served hot to the patient. The ample tray-loading space and the rectangular pan covers accelerate food distribution.

The new Food Conveyor is made entirely of stainless steel, in seamless, sanitary construction. The wells form a single, welded unit with the top deck, eliminating dirt-collecting joints and crevices. The crevice-free construction of the body also provides a continuous surface permitting cleaning by live steam and hot water. **S. Blickman, Inc., Dept. MH, Weehawken, N. J. (Key No. 70)**

Blood Diluting Pipettes

The new Hellige "Three-Line" Pipettes for red and white corpuscles are engraved with only an 0.5 mark in addition to the 1 and 101 marks required for red pipettes and the 1 and 11 marks required for white pipettes. There are only three widely-spaced graduations on the new pipettes and the freedom from superfluous markings eliminates a source of error. The new pipettes are packed individually in boxes, one dozen to a carton. **Hellige, Inc., Dept. MH, 3718 Northern Blvd., Long Island City 1, N. Y. (Key No. 71)**

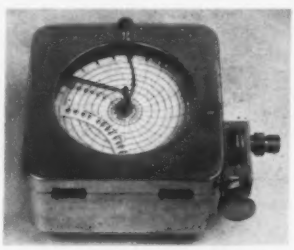
Acoustical Tile

Minatone is a new incombustible perforated mineral acoustical tile added to the Armstrong line of acoustical materials. It is made from mineral wool and binding agents which form a strong homogeneous acoustical unit. It is perforated with 676 holes per square foot and is factory painted with two coats of white latex resin paint on the face and bevels. The tile is 12 by 12 by ⅝ inches.

The low density mineral wool composition blocks the passage of heat and adds insulating properties where installed. The perforated surface of Minatone can be repainted without noticeable loss of sound-absorption efficiency. Although the smooth painted surface resists soiling, it can be cleaned with a slightly dampened cloth or sponge, ordinary wall paper cleaner or a vacuum cleaner. **Armstrong Cork Co., Dept MH, Lancaster, Pa. (Key No. 72)**

Recording Oxygen Flowmeter

An indicating oxygen flowmeter as well as a permanent twenty-four hour



record flow chart are combined in the new Elematic Recording Oxygen Flowmeter. Designed to be directly connected to hospital piping oxygen systems, the meter will also function properly when connected to an oxygen cylinder regulator. The new meter provides a small, accurate and inexpensive measuring device for determining the quantity of oxygen consumed by a patient. At the same time, it contains an accurate flowmeter adjusted to administer any prescribed amount of oxygen.

The meter will accurately record and indicate flows of from 0 to 15 liters per minute. Larger volumes of oxygen may be passed through the meter for purging processes. Back pressure up to 30 P.S.I., which is adequate to cover all types of hospital equipment, does not affect the accuracy of the meter. The permanent record records the flow of oxygen and the time in which oxygen is being administered, thus giving an accurate check on quantity and time of administration. The chart is replaced daily by merely removing a thumb screw. **Elematic Equipment Corp., Dept. MH, 1150 W. Marquette Rd., Chicago 21. (Key No. 73)**

(Continued on page 226)

Food Packaging

The complete line of Gumpert specialty food items for the institutional market has been re-packaged. The new improved package will be in Gumpert's standard orange and black colors for both the cardboard cartons and the cans. The new packages offer added protection during shipping and they are easy to store and pack. Product identification is made easier with a new large, clearly printed label. Easy-to-read directions are printed on every package. More and newer recipes are printed on the new labels. The cans are hermetically sealed and some cartons are individually wrapped in cellophane to ensure freshness. **S. Gumpert Co., Inc., Dept. MH, 812 Jersey Ave., Jersey City 2, N. J. (Key No. 74)**

Sensimatic Accounting Machine

The new multiple register Series 300 Sensimatic accounting machine features automatic control of its operating through a "sensing unit" which is attached to the carriage. As the carriage moves, this control unit transmits a series of rapid fire instructions to the 7000-part working mechanism, indicating the mechanical action to take place. The unit also automatically controls all operations of the carriage. Each of the control units has four complete "brains" to handle four different accounting jobs according to the user's specifications. The operator can switch from one to another by flicking a knob, or the entire unit may be removed and another snapped into position with an entirely new set of Series 300 Sensimatic brains.

The new machine will handle all accounting problems, even the most complex. A new principle of construction employed in all Sensimatic machines allows easy maintenance, in spite of the complicated operations which the machines handle. The machines are made up of nine individual sections

which may be quickly removed when necessary for repairs and adjustments. **Burroughs Adding Machine Co., Dept. MH, Detroit 32, Mich. (Key No. 75)**

MORE CLEANING POWER

TO THE INCH with *Specialized* HILLYARD CARE

Improves floors judged "clean" by ordinary methods

***SUPER SHINE-ALL,** Hillyard's neutral chemical cleaner used on floor pictured, with extra fast wetting acceleration, dissolves dirt by 100% cleansing action that emulsifies oils and greases. Eliminates rinsing which reduces cleaning costs up to 50%. (One of the few cleaners on the market with U/L approval "anti-slip.")

*Reg. U. S. Trademark

The section of floor left, maintained by ordinary methods, might "get by" on casual observance—but when compared to the bright clean appearance of the Hillyard-treated floor right—it's easy to see where "skim-the-surface" methods fail—and *specialized* Hillyard methods succeed.

What you see in the darkened (before) half—is the day by day "pile up" of dirty, grimy, soapy, oily residue left by ineffectual maintenance—and it's the wearing, tearing action of this ground-in dirt or harsh powder that deteriorates sensitive floor surfaces.

AFTER Hillyard's safe wetting action has cut through the tough dulling film—you get the renewed lustre of the original floor surface—and you cut your labor time in half.

SEE THIS DIFFERENCE ON YOUR OWN FLOORS . . .

A HILLYARD FLOOR EXPERT WILL BE GLAD TO ASSIST YOU

A complete staff is serving a nationwide area. If you're having trouble with any floor problem call the Hillyard Maintaineer nearest you.

. . . on your staff not your payroll

FLOOR HILLYARD TREATMENTS

St. Joseph, Missouri

Branches in Principal Cities

Mail this Coupon TODAY!

Hillyard Chemical Company,
St. Joseph, Missouri

Yes—I want to *benefit* by Hillyard's specialized floor cleaning methods. Please send free literature on the proper care of:

☐ **cement** ☐ **terrazzo** ☐ **asphalt**
☐ **wood** ☐ **rubber** ☐ **tile**

*Name*_____ *Title*_____

*Institution*_____

*Address*_____

*City*_____ *State*_____

What's New . . .

Conductive Bootie

The Legge Conductive Bootie is designed to be worn comfortably over ordinary shoes, thus eliminating the need for individually fitted conductive shoes. Positive skin-to-floor contact is maintained by means of a chain which connects the conductive sole with a metal plate worn in an elastic garter around the calf of the leg, or on the flexible conductive band at the top of the Bootie. The Bootie is made of superior grade cotton sail cloth, with conductive sole applied. It is made in three sizes: small, medium and large, for male and female. It is sterilized after each wearing for added sanitary protection as well as safeguarding the sole from the adherence of wax deposits which tend to insulate the wearer from the conductive floor. The Bootie also protects against sparks from the floor to the nail heads of shoes.

The Bootie is light in weight, durable and easily repaired in case of damage. Chain, elastic garter and resistor unit can be removed before sterilizing and easily readjusted afterward, or the entire unit may be wholly sterilized. The manufacturer suggests that Booties be stored in scrub-up rooms adjacent to the operating room. **Walter G. Legge Co., Inc., Dept. MH, 101 Park Ave., New York 17. (Key No. 76)**

X-Ray Tubestand

The new Fluoradex 60-72 ceiling-floor x-ray tubestand has all motions and electric locks controlled directly in front of the operator. It has a wide range of tubehead travel and the tubehead can be angulated 135 degrees to handle the most advanced radiographic technics.

Two models are available in the new unit, the 60 inch and the 72 inch. Either model may be installed as a ceiling-floor or as a wall-floor installation to suit any type of hqspital construction. The floor rail is chrome finished with a rounded surface for ease in keeping it clean. **Westinghouse X-Ray Div., Dept. MH, 2519 Wilkens Ave., Baltimore 3, Md. (Key No. 77)**

Alternating Pressure Pad

Regular, frequent, automatic redistribution of body pressure points is possible with the Alternating Pressure Point Pad for patients with conditions where turning is painful or undesirable. It is used over the mattress, under the bottom sheet, and consists of a vinyl plastic pad with alternating sets of air cells running transversely the width of the regular bed mattress. A small quiet air pump and motor, operating from any 110 volt A.C. outlet, automatically controls the cycle of inflation and deflation of alternate cells. Each cycle is completed every three minutes, thus providing gentle action which does not distract the patient. The mechanical unit is contained in a simple housing which is placed on the floor under the foot of the bed.

The pad corresponds to the dimensions of the standard hospital mattress and has generous tuck-in flaps at head and foot to ensure against slipping, even when the bed is in Fowler position. Use

of the unit does not hinder operation of Gatch sections and the pad is now available for Drinker and Emerson iron lungs and for Stryker frames. **Air Mass Incorporated, Dept. MH, 12720 Lakeshore Blvd., Cleveland 8, Ohio. (Key No. 78)**

Stain-Resistant Tablecloth

Woven of fine quality cotton, "Magic Weave" tablecloths can be wiped clean with a damp cloth. They are treated on one side with Du Pont Fabrilite, a stain-resistant finish which does not chip, crack or peel, nor does it wear out at the corners of the table. It is resistant to hot coffee, fruit acids, alcohol, fats, greases and other foodstuffs. The cloth can be washed in mild suds and warm water and ironed on the uncoated side without affecting the coating which is impervious to heat or cold. Strong bleaching compounds should not be used but boiling water does not change the color or quality of the coating.

The tablecloth is available in white or solid colors, as well as attractive designs in white on white and color on white. The finish makes it possible to provide attractive fabric tablecloths with a linen-like appearance without the necessity of frequent launderings. **Brandwein & Co., Dept. MH, 6 E. Lake St., Chicago 1. (Key No. 79)**

(Continued on page 230)

Hydramizer for Water Tests

The Hydramizer offers a true method of signalling the end of a zeolite softener run. Employing the soap test method, the Hydramizer samples the water periodically and tests it for hardness. If the water is hard a red light appears. If it is still soft a green light glows. For automatic softeners it actuates the automatic valves and for selective automatic or manual units a bell rings to warn the operator that regeneration is necessary.

The unit is economical in cost and in maintenance. The soap container is filled occasionally but no other routine maintenance is necessary. It is a small, compact unit which requires a minimum of space and can be placed on a stand or shelf in the vicinity of the softener. **Refinite Corp., Dept. MH, Box 1312, Omaha, Neb. (Key No. 80)**

Dupli-Kit

Two new machines and all supplies required to print and address postcards, announcements and forms are contained in a handy carrying case about the size of an ordinary tackle box. Called the Dupli-Kit, the unit provides printing and addressing facilities for fast, inexpensive operation.

The Portable Printer accommodates a low cost stencil on which messages are typed, written or drawn. The Portable Addresser utilizes a small roll of paper on which up to 250 addresses are typed. Cards or envelopes are addressed with a single, one-hand motion and each roll can be used for 100 or more impressions. Both Printer and Addresser have gray

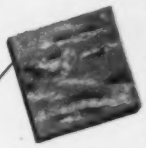
hammerloid finish and fit into the case with the supplies. **The Heyer Corp., Dept. MH, 1850 S. Kostner Ave., Chicago 23. (Key No. 81)**

Your Tile-Tex Contractor

HOLDS THE ANSWER TO YOUR FLOOR AND WALL TILE NEEDS!

TILE-TEX* ASPHALT TILE

A quality, low-cost composition tile that combines decorative beauty and workhorse durability with low initial cost, minimum maintenance and long, long service life.



Comes in 28 rich plain or marbleized colors.

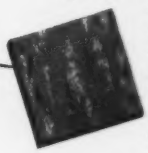
Accurate cut of tile makes joints tight, and lines straight. Its smooth surface makes cleaning easy. No place for dirt to cling.

Ranks high in fire resistance due to its asbestos content.

Readily adjusts to average sub-floor contours at or below grade. Quickly, economically installed.

TUFF-TEX* GREASEPROOF TILE

It's the greaseproof tile for industry. Gives the economy every plant operator wants. Combines high impact resistance with remarkable flexural strength. Withstands constant traffic of heavy materials handling trucks. Offers unusual color and versatility of design . . . either decorative or functional.



Use Tuff-Tex in traffic aisles . . . with built-in safety markers that can't wear off.

Use it in machine areas . . . lubricants, and metal chips can't hurt it . . . in plant food serving areas for kitchen or cafeteria floors.

FLEXACHROME* PLASTIC-ASBESTOS TILE

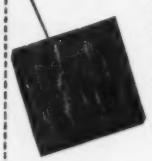
The *ultimate* in resilient composition tile. Richly colorful. Highly resistant to acids and alkalies. Completely greaseproof. Extremely easy to clean because of its extra dense surface.

When it comes to beauty, Flexachrome's *25* brilliant colors are unsurpassed. And its wide range of sizes combine to give you almost unlimited design versatility.

Combining the advantages of ALL types of resilient flooring, Flexachrome is widely used over wood sub-floors. It proves ideal for many areas subject to special abuses, as well as where bright color contrast or a high degree of light reflectancy is desired.

VITACHROME† RESILIENT FLOOR TILE

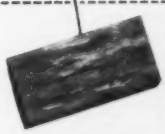
Offers a choice of *especially light, bright* colors . . . and high light reflectancy. It's extremely durable . . . grease and oil resistant.



Plus . . . initial low cost. *Plus* . . . ease and quickness of installation. *Plus* . . . low maintenance. *Plus* . . . ease of cleaning.

Ideal wherever inexpensive, durable and decorative floors are required.

MURA-TEX* PLASTIC-ASBESTOS WALL TILE



Looking for *washable* tile walls that combine decorative beauty with practical durability? . . . Mura-Tex is your lifelong friend.

Here's a wall treatment that is truly modern, featuring color tones that blend perfectly with today's decorating schemes.

Mura-Tex is quickly installed over new or old plaster, or properly built dry wall construction.

It's a popular tile for wainscoting halls, corridors, and utility rooms; and is particularly suited to walls of powder rooms, bathrooms, and kitchens.

Visit your Tile-Tex Contractor's display room. He'll show you all the different colors, sizes, textures . . . show you how tile-at-a-time installation makes possible unlimited designs, lowers maintenance, repair and alteration costs.

You'll find his name in the classified pages of your telephone directory. Or write us for his name and address.

THE TILE-TEX DIVISION, The Flintkote Company, 1234 McKinley Street, Chicago Heights, Illinois.

Tile-Tex—The Pioneer Division, The Flintkote Company, P. O. Box 2218, Terminal Annex, Los Angeles 54, California.

The Flintkote Company of Canada, Ltd., 30th Street, Long Branch, Toronto, Canada.

* Registered Trademark, The Flintkote Company
† Trademark

TILE-TEX . . . HEADQUARTERS FOR FLOORING CONTRACTORS

What's New . . .

Anti-Slip Wax

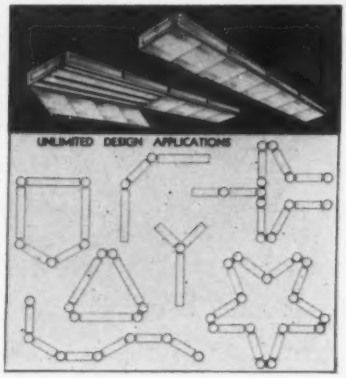
Developed to fill the need for an anti-slip wax with long wearing qualities and one which resists scuffing, Anti-Slip Cosmolite Wax contains yellow carnauba wax with colloidal silica as the anti-slip ingredient. It has been listed by Underwriters' Laboratories, according to the manufacturer.

Anti-Slip Cosmolite Wax is a self-shining product and dries bright with a hard, wear-resistant surface. It does not require frequent buffing to renew the luster, is water resistant and does not water spot. It is described as safe for application on all types of flooring materials. **Huntington Laboratories, Inc., Dept. MH, Huntington, Ind. (Key No. 82)**

Hinged Lens Plexoline

Plexoline fixtures have been in use in quality illumination installations for approximately two years. Day-Brite engineers have now developed a modification of the Plexoline-2 fixture which has a separable hinging arrangement which allows hinging from either side or complete removal for maintenance. Known as the Hinged Lens Plexoline, the new unit is available for either Slimline or fluorescent lamps; an 8 foot unit for two 75-watt Slimline lamps; a 4 foot unit for two 40-watt fluorescent lamps, and an 8 foot unit for four 40-watt fluorescent lamps.

Hot-bonded super-white enamel is used to finish enclosure and chassis of the



fixture. The ribbed glass side panels are of Albalite glass, which has a low brightness and a high light transmission quality. The new Hinged Lens Plexoline is recommended for surface mounting only and top reflector plates are furnished for 100 per cent direct distribution of light.

By combining the Hinged Lens Plexoline, the Plexoline-2 circular units and the adapters, unlimited patterns can be formed to suit the lighting to the individual installation. **Day-Brite Lighting, Inc., Dept. MH, 5451 Bulwer Ave., St. Louis 7, Mo. (Key No. 83)**

Paint Deodorant

Patient rooms, wards, solariums, waiting rooms and other areas of the hospital can now be painted and immediately reoccupied without discomfort because of paint odor. A few drops of "Mask" stirred into any paint or enamel product masks out all offensive fresh paint odors. "Mask" is a chemical product which removes all paint odor from enamels, oil, water and rubber-base paints. When it is used in the paint product, freshly painted rooms can be reoccupied almost immediately and patients are unaware of painting in other rooms or corridors since there is no paint odor.

"Mask" is inexpensive and does not affect any paint characteristic other than the odor. It is the result of careful research and testing and is effective in reducing lost room revenue caused by painting, and in eliminating patient and personnel discomfort. **Duncan-West Corp., Dept. MH, 624 S. Michigan Ave., Chicago 5. (Key No. 84)**

(Continued on page 234)

for health's sake

Sanacoustic* Ceilings provide restful, strength-building quiet so necessary to patients' progress

● Today, with "rest and quiet" playing an ever-increasing therapeutic role, hospitals do everything possible to eliminate noise.

By having Johns-Manville install Sanacoustic Ceilings, you provide quiet, and assure speedier recovery of the patient.

Sanacoustic Ceilings are not only the most efficient available, but they are *noncombustible*. They consist of perforated *metal-panels* backed up with a fireproof, sound-absorbing element. Can be painted and repainted without loss of acoustical qualities. *Baked-enamel finish* makes them easy to keep clean and sanitary. Reception rooms and cafeterias, corridors and lobbies, nurseries and wards are among the "noise centers" especially in need of noise-quieting Sanacoustic.

For hospital areas subject to continuous and excessive moisture, you can choose our perforated Transite* *Asbestos* Panels.

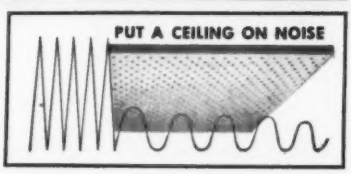
Other J-M Acoustical Ceilings used in hospitals are Fibretone*, a drilled fibreboard for the most modest budget, that can be specified "with flame-resistant finish"; and Permacoustic*, a textured, noncombustible tile with great architectural appeal. For free book on Sound Control or an estimate, write Johns-Manville, Box 60, New York 16, N.Y.

*Reg. U. S. Pat. Off.

JM PRODUCTS

Johns-Manville

SANACOUSTIC CEILINGS



No other window—only **RUSCO** gives you these 6 important advantages

1 EXCLUSIVE MAGICPANEL® VENTILATION CONTROL—a simple adjustment that provides *rainproof, draft-free, filtered-screen ventilation* all year 'round, regardless of weather!

2 BUILT-IN WATERPROOFED FELT WEATHERSTRIPPING. Makes Rusco Windows completely weathertight, eliminates metal-to-metal contact, noise and rattling.

3 POSITIVE AUTOMATIC LOCKING in all open and closed positions. Springbolt action.

4 SMOOTH, EFFORTLESS OPERATION. Rusco sash sections slide up and down in a felt cushion—easily, quietly, without effort.

5 MADE OF TRIPLE-PROTECTED GALVANIZED STEEL for strength, long life and minimum maintenance. Zinc-treated, Bonderized and finished with baked-on outdoor enamel for protection against weathering.

6 GLASS PANELS REMOVABLE FROM INSIDE FOR EASY CLEANING. Upper and lower glass inserts slip out in an instant for safe, convenient, inside cleaning.

For New Construction...

The RUSCO Prime Window

A completely pre-assembled window unit containing glass, screen, weatherstripping, insulating sash (optional) and wood or metal surround. Comes fully assembled, factory-painted, ready to install. Makes big savings in time and labor.

For Weathertight Modernizing...

The RUSCO *Self-Storing* Combination Screen & Storm Sash

Installed without any alteration to present windows. Completely weatherproofs window opening. Provides rainproof, draft-free, filtered-screen ventilation in every kind of weather. The world's best-accepted combination window—over 8,000,000 already installed.

The Beautiful, Sturdy RUSCO Galvanized Steel Combination Screen and Storm Door

Handsome *and* practical! Made of sturdy triple-protected galvanized steel and finished with baked-on outdoor enamel. Won't sag, bind or warp. Lumite screen withstands abuse, can't rust or rot, never needs painting. Self-storing arrangement provides full glass insulation with lower screen for ventilation, as desired. Or, door can be converted *in seconds* to all glass or all screen!

These are just a few of the many Hospitals using RUSCO products:

Mercer Cottage Hospital, Mercer, Pa. • The Huntington County Hospital, Huntington, Ind. • Tecumseh Hospital, Tecumseh, Nebraska • St. Elizabeth's Hospital, Youngstown, Ohio • Nantucket College Hospital, Nantucket, Mass. • Mercy Hospital, Auburn, New York • New England Hospital for Women & Children, Roxbury, Mass. • Newport Naval Hospital, Newport, Rhode Island • Valley View Sanatorium, Haledon, New Jersey.

For full information see your local Rusco Dealer, or write direct to

The F. C. RUSSELL CO.

World Leader in Window Conditioning

Department 6-MH 62 • Cleveland 1, Ohio
In Canada: Toronto 13, Ontario

What's New . . .

Non-Conductive Rubber Slippers

Protection against static electricity sparks in operating rooms is offered in

the new, inexpensive, adjustable Melrose conductive rubber slippers. The slipper is quickly slipped on over the regular shoe and the one piece conductive rubber sole comes over the heel of the shoe and back inside where it fits snugly. Contact with the wearer is established through sock or stocking. Cotton hosiery is recommended as most effective.

Laboratory tests have shown the conductive rubber slippers to be effective for conductivity and aging, even after repeated sterilization by autoclaving or boiling. The adjustable slippers are available in four sizes to fit all doctors, nurses and visitors. **Melrose Hospital Uniform Co., Inc., Dept. MH, 95 Commercial St., Brooklyn 22, N. Y. (Key No. 85)**

Freeze-Dryer

Small hospitals desiccating plasma from out-dated blood will find the new Stokes Model 102 freeze-drying unit able to handle one 250-milliliter bottle. The equipment is supplied with or without vacuum pump and McLeod Gage. Serums, general protein solutions and other materials usually handled in small quantities in the laboratory can be easily dried in the new model. The eight-port manifold has a separate valve on each port to permit aseptic sealing of containers under secondary vacuum and triple connectors permit handling 24 containers at one time. **F. J. Stokes Machine Co., Dept. MH, 5500 Tabor Rd., Philadelphia 20, Pa. (Key No. 86)**

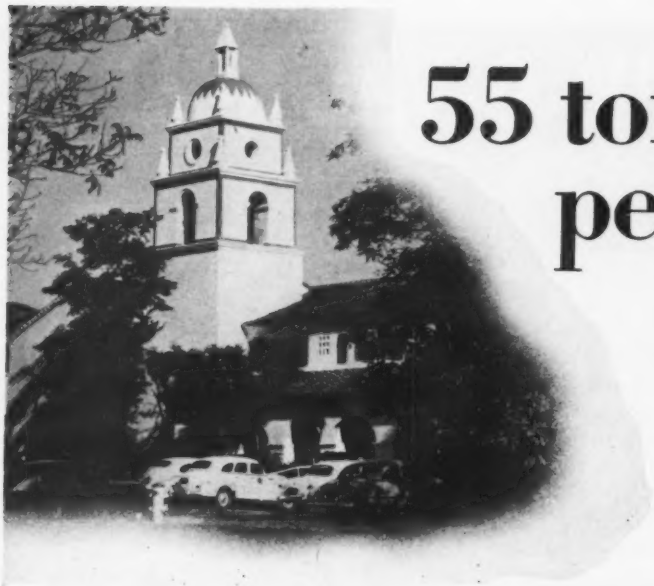
Clarke P-11 Floor Maintainer

Designed to scrub, wax, polish and steel wool floors, the new Clarke P-11 Floor Maintainer is easy to operate. It polishes linoleum, rubber or asphalt tile, terrazzo, concrete or wood flooring quickly and at low cost. It is small and compact, requiring a minimum of floor space when not in use. Of heavy gauge steel construction, the unit is light in weight yet strong and designed for use in all but the largest institutions.

The completely automatic safety switch allows instant stop and start control. Complete mobility is provided by the wheels which are self-retracting when the machine is in operating position. The machine is powered by a ½ h.p. Constant Duty motor that provides abundant power for the new, noiseless, positive drive mechanism. Attachments for the various types of floor care are easy to install and remove. The P-11

is finished in gray hammertone with chrome motor cap and chrome handle. **Clarke Sanding Machine Co., Dept. MH, Muskegon, Mich. (Key No. 87)**

(Continued on page 238)



55 tons per week

"with tested quality work at very low cost per pound"

That's the 15-year experience of Camarillo State Hospital Camarillo, Calif.

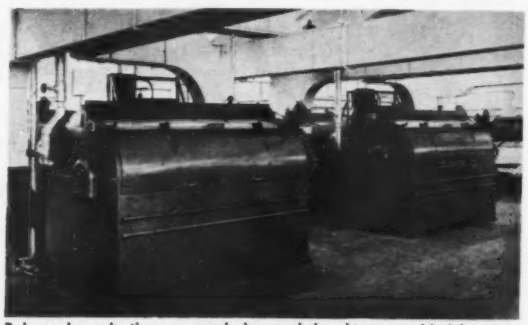
since standardizing with **HOFFMAN** Laundry Equipment

Hoffman hydraulic extractors, capable of extracting 200-pound loads of 5-minute cycles, handle the bulk of extracted work.

In the washroom, eight unloading Hoffman washers and 8-roll flatwork ironers process the present 55-ton weekly volume at Camarillo.

From opening day in 1936, the patient population of this institution has more than doubled, but laundry service has kept pace. Additional equipment has been installed after consultation with Hoffman Laundry planning experts. Most recent changeover has been to mechanized handling, with unloading washers and hydraulic extractors now processing the present 1½ tons-per-hour requirement of over 5,300 patients.

Though your linen requirements may not match those of Camarillo, the principle is the same: take advantage of Hoffman's complete laundry service and gain low costs, smooth work-flow and ample linen supplies.



Balanced production on rough-dry work has been provided by eight Hoffman tumblers. Shown here are two 42 x 90 "Balanced Suction" models.

INSTITUTIONAL ... DIVISION

Hoffman

U. S. HOFFMAN MACHINERY CORP. 105 FOURTH AVENUE, NEW YORK 3, N. Y.

ice

as you want it
when you want it
where you want it

For Anesthesia — For Food Service — For Therapy

The small, compact DER-2 contains all the features of economy and efficiency that characterize the entire line of York Automatic Ice Makers.

- Completely Hermetically Sealed Refrigeration Circuit
- Famous York Compressor
- Rotating Stainless Steel Freezing Drum
- Manganese Bronze Cutter and Collector Blade
- Sanitary Ice Chute
- Baked Enamel Hammertone Gray Jacket
- Underwriters' Laboratories, Sanitary Codes approval
- Only 24" in diameter and 32" tall

The York-FlakIce DER-2 Automatic Ice Maker, the new low-priced addition to the York line, is designed to cut your ice costs and to pay for itself quickly. Only $599.50 f.o.b. York, Pa. . . . it makes up to 300 lbs. of ice a day, using only 15 kilowatt hours of electricity.

So compact, only 24" in diameter x 32" high, it may be installed right at point of use—diet kitchen, utility rooms, cafeteria, snack bar. Compact DER-2s enable your staff to get all the ice they need, when they need it, with no handling, hauling or crushing.

The York-FlakIce DER-2 Automatic Ice Maker makes clear, sparkling, fragment-form ice that cools faster in liquids because it has more cooling surface . . . ice that stays frozen longer when packed because overlapping of particles stops air and heat infiltration. And it's actually *purer* than the water from which it's made.

Your local York Representative, listed in your phone book, will be glad to make a survey of your ice requirements. Give him a call today! Or write direct to York Corporation, York, Pennsylvania.

York refrigeration air conditioning

The big advances come from YORK

Headquarters for — **Refrigeration and Air Conditioning**

What's New . . .

All-Purpose Crib

Model No. 070 is a new improved all-purpose crib equipped with trigger-operated sides that have positive stops at four positions. It has a convenient low spring height of 25 inches and is 77 inches long. Extra narrow filler openings —none over 3 inches wide—are used to assure complete safety, even when occupied by the smallest child.

The new crib is sturdily constructed for long, trouble-free use. Posts are 1½ inch square tubing with all key points ring welded. The ends are 50 inches high and the crib is equipped with 3 inch ball bearing casters. It is available with either full gatch spring or link spring. **Hard Mfg. Co., Dept. MH, 117 Tonawanda St., Buffalo 7, N. Y. (Key No. 88)**

Radioactive Sample Storage

Radioactive samples can be stored in the new Model N4 storage cabinet which incorporates many new design features. It provides for replacing sample holders or the sample tray in case of contamination. Sample holders are plastic cups which are pressed into holes in the tray. In case of contamination these cups can be replaced at small cost. The new cabinet has ten drawers, each containing ten sample holders. Almost any size sample can be accommodated and each sample is numbered for convenience and reference. **Nuclear Instrument & Chemical Corp., Dept. MH, 229 W. Erie St., Chicago 10. (Key No. 89)**

Hot Food Cart

With the new Hospital Hot Food Cart food can be dished up in the main kitchen and served hot to the patient as much as an hour later. This eliminates the necessity for serving kitchens on floors, saves time and ensures food being served hot at the bedside. Three specially designed racks which hold the plates are carried to the dish-up station in the kitchen and loaded in units of eight, then placed in the heated section of the cart. Trays are set up in the kitchen and placed in open shelves of the cart. It is only necessary to put the hot-plate and the hot drink on the

tray at time of serving.

Twenty-four plates and 24 trays can be carried in the cart which has a special heated compartment for coffee, tea and soup. Both regular and special diet service can be provided, as a code to identify plates and trays can be easily set up. Use of the cart speeds up service and permits the serving of meals in minimum time by dietary assistants, without the aid of floor nurses. The cart is 56 inches high, 27 inches wide and 64 inches long. It is easily moved on four 5 inch rubber tired swivel ball-bearing casters. The cart heats quickly when plugged into any ordinary electrical outlet. **Blessing-Hoffmann Corp., Dept. MH, 2422 W. Cermak Rd., Chicago 8. (Key No. 90)**

(Continued on page 242)

". . . free as a nation and financially independent as individuals."

OLIVER P. ECHOLS

Chairman of the Board, Northrop Aircraft, Inc.

"For nearly every American, systematic saving during productive years is the best means of insuring future security. We at Northrop Aircraft believe in the Payroll Savings Plan. We feel that bond purchases contribute great'y toward keeping us free as a nation and financially independent as individuals."

In addition to a deep, personal interest in his own company's Payroll Savings Plan, Mr. Echols is Chairman of the Aircraft Industry Committee to build employee participation in the Payroll Savings Plan.

- When Mr. Echols' Committee was formed, 17 major airframe manufacturers and 11 major suppliers, employing 400,000 workers, had a total of 80,000 employees enrolled in the Payroll Savings Plan.
- At Mr. Echols' request all 28 companies agreed to conduct person-to-person canvasses among their employees.
- The first companies to complete their canvasses report a total of more than 70,000 new Payroll Savers bringing the industry total to more than 150,000 participants.
- In the first reports on campaigns, average payroll participation (companies reporting) went from 20% to 32%. Latest indications are that the average participation—all 28 companies—will be well over 50% by the time the canvasses are completed.
- It is estimated that the 70,000 new Payroll Savers already added to the Plan through the co-operation of Mr. Echols and his Committee will purchase more than 15 million dollars worth of Series E Defense Bonds during the next twelve months.

Has *every* employee of your company been offered an opportunity to enroll in the Payroll Savings Plan? If not, phone, wire or write to Savings Bond Division, U. S. Treasury Department, Suite 700, Washington Building, D. C. Your State Director will help you conduct a person-to-person canvass.

Typical Companies Reporting Results of Person-to-Person Canvasses, Payroll Savings Plan.

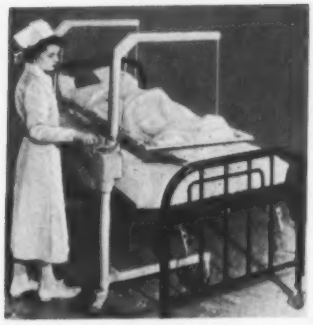
	Before Canvass	After Canvass
Hughes Aircraft	38.7%	85.8%
Continental Motors	10%	70%
Boeing Aircraft	17.8%	55.1%
Rohr Aircraft	1.3%	77.6%
Solar Aircraft	1.8%	60.5%
Bell Aircraft	14%	50%

The U.S. Government does not pay for this advertising. The Treasury Department thanks, for their patriotic donation, the Advertising Council and

THE MODERN HOSPITAL

What's New . . .

Utility Invalift



A smaller, manually-operated version of the Invalift is now available for handling helpless patients. The new Utility Model is light, compact and collapsible and is operated by a handle which is turned with practically no effort. The Invalift raises patients of all sizes conveniently and comfortably with no strain on patient or nurse. When not in use it is small enough to be stored in a closet or carried in an automobile trunk if desired.

Designed for operation in even confined quarters, the Invalift is useful when changing bed linen for a helpless patient, for giving the bed pan, for skin care or therapy and for moving the patient into a wheel chair. It provides a sling for the safe maneuvering of cardiac cases and for transporting a patient from the bed to a stretcher or any other conveyance and back again. It enables helpless patients to be moved with no sense of insecurity or discomfort. **Invalift, Inc., Dept. MH, 4617 Airport Way, Seattle 8, Wash. (Key No. 91)**

Roof Coolerant

Roof Coolerant is a solution which is brushed or sprayed on roofs to deflect the bulk of the sun's radiant heat and thus reduce below-roof temperatures. It consists of large flakes of metallic aluminum applied with a special liquid bond, creating a complete, seamless, silver blanket which throws back the sun's heat. It stays bright with long use and prevents rapid drying out of the roof. **Tropical Paint & Oil Co., Dept. MH, 1246 W. 70th St., Cleveland 2, Ohio. (Key No. 92)**

Upright Filing Cabinet

X-rays, charts, drawings, photographs, blueprints and other large pieces can be filed safely and conveniently, without wrinkles, creases or curled edges, in the new Draw-In-Dex upright filing cabinet. The cabinet has been carefully designed and engineered to meet the problem of filing large sized sheets. Each item hangs smoothly and an index file locates it instantly. All items are immediately accessible and any one can be removed without disturbing the others.

Blueprints and other items are supported on suspension rods and easily attached to manila hangers. Newly developed aluminum hangers permit filing a large number of drawings or other items together. When the front panel is opened, any sheet can be immediately filed or removed. The cabinet stands

four feet high, has steel top and sides and is finished in gray, green or brown. **Berwin Trading Co., Dept. MH, 15 Park Row, New York 38. (Key No. 93)**

(Continued on page 244)

schools ↓ *Children's Home Society Building, Trenton, New Jersey*
Architects: Michelwright & Mountford, Trenton, N. J.
Const. Eng.: Pennell & Wilkberger, Philadelphia, Pa.

How Dunham Vari-Vac Heating

Cuts fuel costs up to 40%

You can save up to 40% on fuel bills with Dunham Vari-Vac* Differential Heating. Why? Because this high vacuum, precision temperature control system *uses less steam* to heat any building . . . regardless of its size, type, age, or location.

On mild days, for example, Dunham Vari-Vac *expands* smaller quantities of "cool" subatmospheric steam. And on cold days, no matter how rapidly outside temperatures change, Vari-Vac automatically delivers the *exact* amount of heat needed. No more. No less.

Choice of systems. 7 different Vari-Vac systems are available, varying only in the degree of automatic control desired. For complete information, see your Dunham Sales Engineer . . . or write for Bulletin 2101-19.

**Variable Vacuum.*

hospitals ↑ *La Raza Hospital, Mexico City D. F., Mexico*
Architect: Enrico Yanez, Mexico City D. F., Mexico
Const. Eng.: Salvadore Tejeda, Mexico City D. F., Mexico

Send for Free Booklet 2101-19

Tells all you will need to know about this amazing system—how it operates, how it may be fitted exactly to your needs. Write for your copy.

DUNHAM

heating systems and equipment

C. A. DUNHAM COMPANY
400 W. Madison Street, Chicago 6, Illinois
In Canada: C. A. Dunham Co., Ltd., Toronto
In England: C. A. Dunham Co., Ltd., London
Radiation • Unit Heaters • Pumps • Specialties

Instantaneous response to outside weather changes.

Convenience of centralized operation.

Automatic compensation for heat loss.

Heat supply and demand perfectly balanced.

What's New . . .

Nest-Kart Mobile Conveyors

Familiar to anyone who shops in chain grocery stores are the telescoping Nest-Karts. These sanitary, steel carts are now being made available to hospitals for the conveyance of small pieces of equipment and machines, book distribution, file room collection, the carrying of medications, bandages, splints, casts and surgical instruments. In the kitchens and serving rooms the moving of dishes, pots, pans and cooking utensils can be facilitated by their use. Ball bearing axle rubber wheels with cushioned tread make the carts practically noiseless.

The Type SW-50 Nest-Karts (illustrated) have a basket capacity of 4500 cubic inches with a large built-in lower basket. Small items baskets are also available. **Continental Fixtures Co., Dept. MH, Oklahoma City, Okla. (Key No. 94)**

Tea Server

Tea served in the new Universal individual two-cup beverage server does not pick up a metallic taste and the second cup is hot when poured. It is a thermal server, Fiberglas insulated, which holds temperatures for long periods of time. The chrome plated shell is attractive and easily cleaned and the molded melamine plastic liner can be easily replaced if necessary. The "Seal-tite" cover seals in heat or cold. The interior of the server is easily cleaned and sterilized. The server has an easy pouring spout, a 10 ounce capacity and a die-cast handle which stays cool. **Landers, Frary & Clark, Dept. MH, New Brittain, Conn. (Key No. 95)**

Brush Dispenser

The new Amsco Brush Dispenser holds 13 of the popular sized sterile hand brushes for the scrub-up room. Brushes are inserted into the holder through opening the door. They are released for use from Model No. 3607 by a step on the foot pedal. Model No. 3606 has a handle for dispensing a brush by a push of the elbow.

Each dispenser is supplied complete with a metal wall board and three mounting screws. The screws are fastened to the wall and the container is attached by setting over the screws. It

is easily removed for autoclaving. **American Medical Specialties Co., Inc., Dept. MH, 12 E. Twelfth St., New York 3. (Key No. 96)**

(Continued on page 246)

What's New . . .

Pharmaceuticals

Armatinic Special Capsulettes

Armatinic Special Capsulettes are a new formulation, of value in certain anemias. Each Capsulette contains folic acid 1 mg., Crystamin 10 mcg., ascorbic acid 50 mg., and liver fraction 2 (NF) with duodenum 350 mg. Crystamin is the Armour brand of crystalline vitamin B_{12}. The new product is indicated in certain macrocytic anemias and in the macrocytic anemias of sprue and nutritional origin as well as for the growth-producing effect of the B_{12}. Armatinic Special is available in bottles of 100 Capsulettes. **The Armour Laboratories, Dept. MH, 520 N. Michigan Ave., Chicago 11. (Key No. 97)**

Nalline

Nalline is a specific antidote to overdosage of morphine and certain other narcotics. It has been found to offset the respiratory depression which might be brought about through overdosage with morphine and its derivatives, as well as meperidine and methadone. Intravenous administration is recommended for most rapid antidote action. The substance is the product of several years of research by Merck scientists and by outside investigators, working in collaboration with the Committee on Narcotics of the National Research Council. Nalline is an opium derivative and therefore subject to Federal narcotic laws and regulations. It is not a cure for drug addiction and is not active against the respiratory depression produced by barbiturates, cyclopropane or ethyl ether. It has been found to have value in obstetrics. Nalline is available as solution of Nalline Hydrochloride in ampules containing 10 mg. of active substance in 2 cc. of aqueous solution. **Merck & Co., Inc., Dept. MH, Rahway, N.J. (Key No. 98)**

Ditubin

Ditubin, brand of isonicotinic hydrazide, the new antitubercular compound, is being offered by Schering Corporation to every state, county, city and semi-private tuberculosis hospital and sanatorium in the United States having a bed capacity of more than 100, for clinical investigation. Selected hospitals in Canada also will be supplied. The immediate need for clinical confirmation of the early investigations has prompted the donation of this supply of the drug to hospitals specializing in tuberculosis therapy. **Schering Corp., Dept. MH, Bloomfield, N.J. (Key No. 99)**

P N S Rectal Suppository

P N S Rectal Suppository combines the effectiveness of Pontocaine, Neo-Synephrine and Sulfamylon. Designed for the treatment of inflammatory rectal conditions, including hemorrhoids, and for application before and after operations, the P N S suppository simultaneously helps retard bacterial growth, relieves pains and reduces congestion. It is applied rectally after each bowel movement and upon retiring. The suppositories also contain bismuth subfallate, which acts as a siccative antiseptic, and balsam of Peru, for a soothing action, in a cacao butter base. They are supplied in boxes of 12. **Winthrop-Stearns Inc., Dept. MH, 1450 Broadway, New York 18. (Key No. 100)**

"Simpremex" Injectable

"Simpremex" Injectable combines both water-soluble conjugated estrogens equine (Premarin$_R$) and water-insoluble estrone. When reconstituted with accompanying sterile diluent it provides a solution for rapid absorption and utilization and a suspension of estrone for a slower and more sustained response. **Ayerst, McKenna & Harrison Ltd., Dept. MH, 22 E. 40th St., New York 16. (Key No. 101)**

(Continued on page 248)

What's New . . .

Product Literature

• The very complete line of metal furniture manufactured by Royal Metal Mfg. Co., 175 N. Michigan Ave., Chicago 1, is illustrated and described in the catalog, **"Built On a Foundation of Quality,"** recently released. A brief history of this 55 year old company is given in the opening pages of the 64 page catalog which also carries editorial type text on construction details and fabrics. Attractive color illustrations show the modern line of settees, chairs, tables, stools, shelving, counters, shop equipment, library shelving, storage equipment and cabinets made by the company. **(Key No. 102)**

• The American Meat Institute Foundation at the University of Chicago, Chicago 37, has published a booklet, "New Methods for New Times," which gives a factual and photographic introduction to the foundation. It discusses the foundation, cooperation with the meat industry, research projects being undertaken and the benefits resulting. **(Key No. 103)**

• A new fully illustrated booklet on the automatic, self-contained **Clayton Steam Generator** has just been released by the Clayton Mfg. Co., El Monte, Calif. Details are given on specific applications of the equipment as well as on models and sizes available. **(Key No. 104)**

• **General Electric Co., X-Ray Department,** 4855 Electric Ave., Milwaukee 14, Wis., has published an attractive booklet containing a preview of an interesting series of advertisements to appear in *Newsweek* magazine. Pointed to the general public, the series features medical and hospital illustrations, each with brief text accenting the thought illustrated. **(Key No. 105)**

• **Dura-Decor coated Fiberglas drapery and curtain fabrics** are described and swatches included in the new catalog recently released by Duracote Corporation, 350 N. Diamond St., Ravenna, Ohio. Dura-Decor fabrics are designed for use as stage curtains, window draperies, room-darkening curtains, room dividers and decorative draperies in schools and other public buildings. The fabrics are made by coating a Fiberglas reenforcing cloth, woven of fine, strong, pliable and inorganic glass yarns, with a long-life synthetic resin which will not harden, crack or peel. The resulting fabrics are permanently fire resistant, can be cleaned by dusting or sponging and have long life, even under abusive, abnormal use. The fabrics retain their original attractive appearance. **(Key No. 106)**

• An attractively presented booklet presents a pictorial story of the new **Hill-Rom Safety Side and Safety Step.** Descriptive text supplements the effective pictures which illustrate the several uses of these bed accessories under all circumstances. Also illustrated and described is the No. 30-M motor-driven high-low bed. The booklet is available from the Hill-Rom Company, Inc., Batesville, Ind. **(Key No. 107)**

• Amplifying the theme, "No air conditioning system is better than its air distribution," is the new **Selection Manual 40** released by Anemostat Corporation of America, 10 E. 39th St., New York 17. The second, revised edition is a 64 page manual containing a complete new section on Anemostat High Pressure Units for high pressure, high velocity systems. The manual is generously illustrated with photographs and tables on performance data. It is plastic bound to lie flat when open. **(Key No. 108)**

• **"Do You Operate Your Own Laundry Plant?"** is the question on the first page of a folder describing the Unitowel system for quality towel service at low cost. Concise information on this system, which keeps the washrooms neat and clean and is easy to operate, is provided in the folder issued by The Unitowel Company, 29 S. La Salle St., Chicago 3. **(Key No. 109)**

(Continued on page 250)

"But how modern will these rooms be 20 years from now?"

HE WANTS his fellow hospital board members to make an important decision. Listen:

"20 years from now, Individual Room Temperature Control will still be the most modern way to control temperatures in hospital rooms, just as it is today! So, unless we want our new hospital to be outdated before it opens, we should install Individual Room Temperature Control now, while we're still building, when it only costs ½ to 1% of our total expenditure."

Sound, businesslike reasoning, isn't it? And here's why he's so convinced.

Today, in many hospitals, it is already routine medical practice to give each patient the exact room temperature he needs to speed his convalescence. And you can do this *only* with Individual Room Temperature Control. No other method can compensate for the varying effects of wind, sun, open windows and variations of internal load in each room.

Since that is true, it's wise to install Individual Room Temperature Control *when your hospital is being built.* Doing it later, as a modernization project, is sure to cost substantially more money.

For complete facts on Honeywell controls for your hospital, call your local Honeywell office — there are 91 in key cities throughout the nation. Or for literature, write Honeywell, Dept. MH-6-137, 351 E. Ohio St., Chicago 11, Illinois.

MINNEAPOLIS **Honeywell**

First in Controls

Only thermostat specially designed for hospitals!

No other hospital thermostat offers all these features:

- ***"Nite-Glowing dials"*** permit inspection without disturbing patients.
- ***Magnified numerals*** make readings easy to see.
- ***New Speed-Set control knob*** is camouflaged against tampering.
- ***Air-Operated;*** requires no electrical connections.
- ***Lint-Seal*** insures trouble-free operation.

What's New . . .

• **"What Regulator Should I Use?"** is the title of a new folder issued by Puritan Compressed Gas Corp., 2012 Grand Ave., Kansas City 8, Mo. It is designed to aid in selecting the correct type of oxygen regulators for specific applications throughout the hospital. Regulators for use with surgical and other equipment are included, as well as therapy regulators. The folder discusses the distinction between the methods of pressure reduction in single and in two stage regulators and tells what performance to expect of each type. It also points out the difference in measuring liter flow with spring-type flow gauges and with tube-type flowmeters. **(Key No. 110)**

• **Bulletin LS5-1951** is a new publication of the Cannon Electric Co., 3209 Humboldt St., Los Angeles 31, Calif., covering experimental switchboard and laboratory cord connectors. Two new fittings recently added to the laboratory and switchboard line are cataloged for the first time. **(Key No. 111)**

• **Lea & Febiger Books for 1952** are completely cataloged in a new 56 page booklet released by Lea & Febiger, Washington Square, Philadelphia 6, Pa. The list covers books on medicine, pharmacy, nursing, dentistry and other professional subjects. **(Key No. 112)**

• A new booklet has just been released on **Aloe Hospital Equipment Layout and Planning Service** by A. S. Aloe Co., 1831 Olive St., St. Louis 3, Mo. How the service operates is discussed in the booklet and the various areas of the hospital are illustrated by actual photographs, some in full color, with descriptive text. **(Key No. 113)**

• **"Plibrico Refractory Products for Firebox and Other Heating Boilers"** are discussed in a new bulletin released by the Plibrico Jointless Firebrick Co., 1800 Kingsbury St., Chicago 14. The application of Plibrico monolithic linings to firebox and similar types of heating boilers, air-cooled as well as solid refractory construction, and engineer's specifications for the refractory lining and outside wall construction for boilers are included in the bulletin. **(Key No. 114)**

• **"Solving Roof Problems"** is the title of a new 32 page roof maintenance brochure released by The Tremco Mfg. Co., 8701 Kinsman Rd., Cleveland 4, Ohio. Illustrated by photographs, drawings and diagrams, the brochure explores such subjects as the various types of roofs, how they are built, what factors enter into their deterioration, and how roof troubles can be diagnosed and treated. It is divided into 15 sections and a table of contents. **(Key No. 115)**

• How **Flexoprint** is used in preparing directories, catalogs, indexes, rosters and other listings where accuracy is essential is described in Bulletin KD 610 issued by Remington Rand Inc., 315 Fourth Ave., New York 10. Flexoprint eliminates typesetting and proofreading and permits quick and easy changes simply by adding or removing typewritten cards, thus making it possible to keep lists up to date. **(Key No. 116)**

• A pocket-sized folder on **"Otis Colors"** has been released by Otis Elevator Co., 260 Eleventh Ave., New York 1. It contains 48 sample swatches illustrating colors in which elevator car interiors and hoistway entrances may be finished. They are the colors of the new baked enamel finishes which have recently come into wider use for elevator interiors and entrances. **(Key No. 117)**

• **"Cold Facts on Hot Air"** is the title of a folder giving statistics on the costs of various hand drying technics. The figures are presented in chart form for easy analysis and are supplemented by a discussion of the use of Electric-Aire hand dryers in public washrooms and the resulting neatness, economy and reduced maintenance. The folder is available from Electric-Aire Engineering Corp., 209 W. Jackson Blvd., Chicago 6. **(Key No. 118)**

(Continued on page 252)

NEW *exclusive*

Pfizer *Steraject Syringe*

holds 2 sizes of disposable cartridge

Sterile, single-dose

Steraject

disposable cartridges

and in the widest [illegible] of antibiotic dosage forms available!

Steraject Penicillin G Procaine Crystalline in Aqueous Suspension (300,000 Units)

Steraject Penicillin G Procaine Crystalline in Oil with 2% Aluminum Monostearate (300,000 units)

NEW

Steraject Penicillin G Procaine Crystalline in Aqueous Suspension (1,000,000 units)

Steraject Combiotic* Aqueous Suspension (400,000 units Penicillin G Procaine Crystalline, 0.5 Gm. Dihydrostreptomycin)

Steraject Dihydrostreptomycin Sulfate Solution (1 gram)

Each cartridge individually cartoned with foil-wrapped sterile needle: in shelf packs of 25. Also in bulk cartons of 100 with needle adaptors.

Note to Hospital Superintendent

Steraject *offers you this*
5 point economy program.

1. *No costly syringe breakage.*
2. *Eliminates time-consuming preparation of antibiotic solutions and suspensions.*
3. *Eliminates waste of unused portions of multiple-dose vials.*
4. *Accurate pre-measured dose in each cartridge. No loss from inaccurate withdrawal from multiple-dose vials.*
5. *Reduces your replacement cost for needles.*
6. *Simplifies storage.*
7. *Single-dose Sterajects are accountable—for inventory control, cost analysis and billing.*
8. *Time saving on the floor.*

*TRADEMARK, CHAS. PFIZER & CO., INC.

Ask your Pfizer Hospital Representative on his next call!

Pfizer *World's Largest Producer of Antibiotics*

ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC., BROOKLYN 6, N. Y.

What's New . . .

• A 12 page practical guide for economical and efficient care of floors is presented in **"Floors Without Flaws"** released by A. C. Horn Company, Inc., 10th St. and 44th Ave., Long Island City 1, N. Y. Information included covers the conditioning, repairing and maintenance methods for the widest variety of floor materials: concrete, asphalt tile, cork, linoleum, magnesite, terrazzo and wood. Each type of floor is separately considered and details of maintenance discussed. **(Key No. 119)**

Book Announcements

Huffman, "Manual for Medical Records Librarians," completely revised 3rd ed., 512 pp., $7.50. **Physicians' Record Co., Dept. MH, 161 W. Harrison St., Chicago 5. (Key No. 120)**

McClain, "Simplified Arithmetic for Nurses," 151 pp., $2. Mainland, "Elementary Medical Statistics, The Principles of Quantitative Medicine," 327 pp., $5. Petry, "The Encyclopedia of Nursing," 1011 pp., $4.75. Salter, "A Textbook of Pharmacology, Principles and Application of Pharmacology to the Practice of Medicine," 1240 pp., $15. "Postgraduate Medicine and Surgery—Surgical Forum American College of Surgeons," 667 pp., $10. **W. B. Saunders Co., Dept. MH, W. Washington Square, Philadelphia 5, Pa. (Key No. 121)**

Garesche, "Your Stay in the Hospital," revised and enlarged edition, $1.50 stiff cover, $.50 paper. **Vista Maria Press, Dept. MH, 8 W. 17th St., New York 11. (Key No. 122)**

THIS COUPON is provided for your convenience in requesting additional information.

- ☐ 65 Sterilized Surgical Blades
- ☐ 66 Synthetic Detergent
- ☐ 67 Automatic Ice Flake Maker
- ☐ 68 Permon Wainscot
- ☐ 69 Nurses "Capping" Lamp
- ☐ 70 Heated Food Conveyor
- ☐ 71 Blood Diluting Pipettes
- ☐ 72 Minatone Acoustical Tile
- ☐ 73 Recording Oxygen Flowmeter
- ☐ 74 Food Packaging
- ☐ 75 Sensimatic Accounting Machine
- ☐ 76 Conductive Bootie
- ☐ 77 X-Ray Tubestand
- ☐ 78 Alternating Pressure Pad
- ☐ 79 Stain-Resistant Tablecloth
- ☐ 80 Hydramizer for Water Tests
- ☐ 81 Dupli-Kit
- ☐ 82 Anti-Slip Cosmolite Wax
- ☐ 83 Hinged Lens Plexoline
- ☐ 84 Paint Deodorant
- ☐ 85 Non-Conductive Rubber Slippers
- ☐ 86 Freeze-Dryer
- ☐ 87 Floor Maintainer
- ☐ 88 All-Purpose Crib
- ☐ 89 Radioactive Sample Storage
- ☐ 90 Hot Food Cart
- ☐ 91 Utility Invalift
- ☐ 92 Roof Coolerant
- ☐ 93 Upright Filing Cabinet
- ☐ 94 Nest-Karts
- ☐ 95 Tea Server
- ☐ 96 Amsco Brush Dispenser
- ☐ 97 Armatinic Special Capsulettes
- ☐ 98 Nalline
- ☐ 99 Ditubin
- ☐ 100 P N S. Rectal Suppository
- ☐ 101 "Simpremex" Injectable
- ☐ 102 "Built on Quality"
- ☐ 103 "New Methods"
- ☐ 104 "Clayton Steam Generator"
- ☐ 105 Advertisements
- ☐ 106 Dura-Decor Fabrics
- ☐ 107 Booklet on Safety Sides
- ☐ 108 Selection Manual 40
- ☐ 109 "Do You Operate Your Laundry?"
- ☐ 110 "What Regulator Should I Use?"
- ☐ 111 Bulletin L55-1951
- ☐ 112 Book Catalog
- ☐ 113 Hospital Equipment Layout
- ☐ 114 "Plibrico Refractory Products"
- ☐ 115 "Solving Roof Problems"
- ☐ 116 Flexoprint Bulletin
- ☐ 117 "Otis Colors"
- ☐ 118 "Cold Facts on Hot Air"
- ☐ 119 "Floors Without Flaws"
- ☐ 120 Medical Records Book
- ☐ 121 Books
- ☐ 122 Book

I should also like to have information on the following products

_____

_____

NAME _____ **TITLE** _____

HOSPITAL _____

STREET _____

CITY _____ **ZONE** _____ **STATE** _____

MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc. 919 N. Michigan Ave., Chicago 11, Ill.

Suppliers' News

W. A. Baum Co., Inc., manufacturer of medical instruments, announces removal of its offices from **460 W. 34th St., New York 1,** to **Copiague, Long Island, N. Y.**

The Colson Corporation, Elyria, Ohio, manufacturer of Colson casters, trucks and invalid chairs and other hospital equipment, announces the closing of its **Boston** sales office at **10 Postoffice Square** and the appointment of the **Charles P. Lauman Co., 99 Bedford St., Boston 11, Mass.** as its distributor for the New England area.

Darnell Corporation, Ltd., manufacturer of casters, announces removal of its offices from **Long Beach, Calif.** to **12000 Woodruff Ave., Downey, Calif.**

Libbey Glass, division of Owens-Illinois Glass Co., Toledo 1, Ohio, announces the opening of two new branch offices. The new office in **Pittsburgh, at 1913 Clark Bldg.,** will be under the management of **Robert C. Malone.** That in **Richmond, Va., at 918 Central National Bank Bldg.,** will be managed by **James A. Baugh.**

Nu-Grain Corporation—Correction. In the May issue in this department an announcement appeared of the new Hospital Division opened by this firm of furniture modernizers and refinishers. Unfortunately an error was made in the address. The correct address of the Chicago office, and of the new **Hospital Division,** is **6033 S. Lafayette Ave., Chicago 21.**

Sharp & Dohme, Inc., 640 Broad St., Philadelphia 30, Pa., manufacturer of pharmaceuticals and biologicals, recently dedicated the new four million dollar **Sharp & Dohme Medical Research Laboratories** at **West Point, Pa.,** to the service of the medical and allied professions and the nation's health. As a part of the dedication program, a symposium on "Frontiers of Research on Blood and Plasma Extenders" was presented with a panel of six leading scientists in this field of medicine. A comprehensive description of the research facilities now available in the new laboratories has been prepared by the company.

U. S. Hoffman Machinery Corp., 105 Fourth Ave., New York 3, manufacturer of laundry machinery, announces the removal of its **Boston** branch office to new, larger quarters at **535 Commonwealth Avenue** in that city.

Wyandotte Chemicals Corp., Wyandotte, Mich., manufacturer of detergents for cleaning and sanitation, announces removal of its **Syracuse** office to **541 Seneca St., Buffalo 4, N. Y.,** in order to be more centrally located in the territory.

Printed in U. S. A.

PREFERRED
for ICE WATER SERVICE

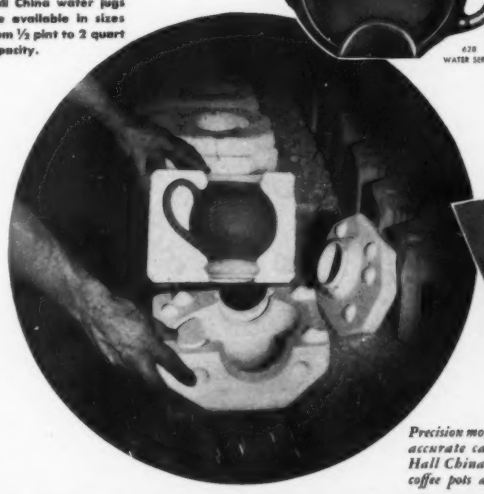
Hall China water jugs are available in a wide variety of shapes for service in every type of institution. They are made of heavy, absorption-proof china by an exclusive process—which gives them extra strength and sturdiness to stand hard use . . . and a smooth surface which can be kept sparkling with a minimum of cleaning and sterilizing.

Hall China water jugs are available in sizes from ½ pint to 2 quart capacity.

Write on company letterhead for Catalog 48, which lists almost 1,000 different Hall China items and contains a color chart of the 26 beautiful underglaze colors that are available.

THE HALL CHINA COMPANY · EAST LIVERPOOL, OHIO

The World's Largest Manufacturer of Fireproof Cooking China



Precision molds assure accurate casting of Hall China teapots, coffee pots and jugs.

HALL
Secret Process
FIREPROOF CHINA

WELTON BECKET & ASSOCIATES
architects
RALPH E. PHILLIPS, INC.
mechanical engineers
P. J. WALKER COMPANY
general contractors
HOWE BROTHERS
plumbing contractors
KEENAN PIPE & SUPPLY CO.
plumbing wholesalers

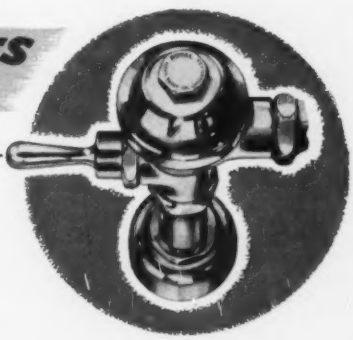
ABOVE • *New home of General Petroleum Corporation, Los Angeles.*

AT LEFT • *Spiral garage of revolutionary design, for General Petroleum employees. Over 450 cars can be parked by drivers themselves, at right angles to the center traffic lanes on the continuous ramp 60 feet wide.*

A LIMIT?..YES AND NO!

In Los Angeles the building height limit is 150 feet, but there is no limit on architectural innovations. This is ably demonstrated in the praiseworthy General Petroleum Building, the exterior of which is distinguished by huge vertical aluminum fins which shield office windows from the intense sun. Inside, movable partitions permit offices to be expanded or contracted quickly and at trifling cost to meet changing space needs. These and other unique features make the West Coast home of the "Flying Red Horse" a business building of high rank. In both buildings pictured, as in thousands of other high ranking buildings, efficient, economical and enduring SLOAN *Flush* VALVES were installed throughout—more proof of preference that explains why . . .

more **SLOAN *Flush* VALVES**
are sold than all other makes combined



SLOAN VALVE COMPANY • CHICAGO • ILLINOIS

Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. When turned on it delivers cone-within-cone spray of maximum efficiency. When turned off it drains instantly. It gives greatest bathing satisfaction, and saves water, fuel and maintenance service costs.

Write for completely descriptive folder